

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3212 **CERTIFICATE OF DEATH** **03200**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN lb <u>35 min</u>				d. STREET ADDRESS <u>1515 Granville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Stn & Hosp</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter Cecil</u>				4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-26-87</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Worcester, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Allen</u>				14. MOTHER'S MAIDEN NAME <u>Maria Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>377-03-0058-A</u>		17. INFORMANT <u>MR Walter F. Allen</u> Address <u>Same as deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized and coronary atherosclerosis</u> (c) <u>several years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Carcinoma of the rectum</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, tectory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital), attended the deceased from <u>February, 1961</u> to <u>March 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 29, 1961</u> , and that death occurred at <u>7:30 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 29, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>				22d. ADDRESS <u>9301 Coleville Rd, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Gilka</u>				25a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

0350

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3213

CERTIFICATE OF DEATH

03201

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 134 days c. LENGTH OF STAY IN lb 134 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 2813 Burgundy Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Edmund John ANDERSON		4. DATE OF DEATH Month March Day 27 Year 19 61		5. SEX Male									
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-28-17									
9. AGE (In years last birthday) 43 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
	Hours												
	Min.												
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Joseph ANDERSON									
14. MOTHER'S MAIDEN NAME Ida Amele ULRICH		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII-Korean		16. SOCIAL SECURITY NO. 223-50-6258									
17. INFORMANT (W) Mrs. Arrietta E. Anderson, same as #2 above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma (Primary unknown) DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 199X stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 mos									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) Nov. 9 1960 to March 27, 1961		(County) 7:23AM		(State) that (X) (we) last saw the deceased alive on March 27 19 61, and that death occurred at M, from the causes and on the date stated above.									
21. I certify that		22a. SIGNATURE R. C. THOMAS, LT, MC, USN		22b. DATE SIGNED 3-27-61									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 30, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National									
23d. LOCATION (City, town or county) Arlington		(State) Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley, 1500 W. Braddock Rd., Alexandria									
25a. REC'D BY REGISTRAR MAR 30 '61		25b. REGISTRAR'S SIGNATURE Charles L. Thomas											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03202

3214

Item 2 Film 0282 3/11/61 mh

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Va.</i> b. COUNTY <i>Montgomery</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN 1b <i>83 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Kathryn</i> Middle Last <i>Barber</i>		4. DATE OF DEATH Month <i>7</i> Day <i>5</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 27-1878</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>John Burke</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Malloy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Chart</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 12</i> 19 <i>60</i> to <i>March 5</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>March 5</i> 19 <i>61</i> , and that death occurred at <i>11:20 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>James M. Whitlock</i> M.D.		22b. DATE SIGNED <i>March 6, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>		22d. ADDRESS <i>7717 Canallary Takoma Park Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>Mar 8 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenlawn Maus.</i>	23d. LOCATION (City, town, or county) (State) <i>Martinsville Indiana</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Murphy</i>		25. REC'D BY REGISTRAR <i>Arthur S. Kross</i>	
ADDRESS <i>Carl 4th</i>		DATE <i>MAR 9 '61</i>	

1893

RECEIVED

1893

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

TO "HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO "GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

3215										03203									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5503 Charlcote Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Lida First Middle Last BARNES					4. DATE OF DEATH Month Day Year March 22 1961														
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-73		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY - - - - -					11. BIRTHPLACE (County & State, or foreign country) Pennsylvania					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William WILLIAMS					14. MOTHER'S MAIDEN NAME Zadie KASSON														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Address (D) Mrs. Frances W. B. Miller, same as #2 above									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, myocardium 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c) Arteriosclerotic heart disease DUE TO cause listed. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Volvulus, cecum										INTERVAL BETWEEN ONSET AND DEATH 12 Hours Years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (a) (this hospital) attended the deceased from March 21 1961 to March 22 1961 , that (b) (we) last saw the deceased alive on March 22 1961 , and that death occurred at 6:45 AM , from the causes and on the date stated above.																			
22a. SIGNATURE G. A. Magid M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					3-22-61 22b. DATE SIGNED XXXXX									
22c. PHYSICIAN'S NAME (Type) G. A. MAGID, LT, MC, USN																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 3-24-61					23c. NAME OF CEMETERY OR CREMATORY Arlington National					23d. LOCATION (City, town or county) (State) Arlington Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumfrey ADDRESS R. A. Pumfrey Funeral Home, Bethesda, Md.					25a. REC'D BY REGISTRAR DATE MAR 24 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Hines									



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(D) 1970-1971

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3216

03204

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>30 Years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 E. Wayne Avenue</u>				d. STREET ADDRESS <u>200 E. Wayne Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>W.</u> Last <u>Barrows</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 10, 1886</u>			
9. AGE (In years lost birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Gen'l Conf, S.D.A</u>		11. BIRTHPLACE (State or foreign country) <u>Randolph, Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Willis Barrows</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Sumner</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lillian Barrows 200 E. Wayne Ave., Sil. Spr., Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Pancreas -</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15th 1961</u> to <u>March 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1961</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Lyle Williams</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Lyle Williams</u>			
22d. ADDRESS <u>8700 Colesville Rd, Silver Spring, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>March 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				24a. ADDRESS <u>254 Carroll St, N.W. Wash, D.C.</u>		24b. REC'D BY REGISTRAR <u>DATE MAR 13 '61</u>			
24c. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>				24d. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1910

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3217 CERTIFICATE OF DEATH 03205											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge d. STREET ADDRESS 121 "D" Preston Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Katherine Melvina BASS				4. DATE OF DEATH Month March Day 16 Year 19 61							
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-17-61		9. AGE (In years last birthday) yrs. 27		IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min. 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) Maryland Cecil		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kenneth R. BASS				14. MOTHER'S MAIDEN NAME Lucille M. DUGIE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus, congenital DUE TO Conditions, if any, which gave rise to immediate cause (b) 752X (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										INTERVAL BETWEEN ONSET AND DEATH 27 days	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 20 1961 to March 16 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 16 1961 , and that death occurred at 12:10PM , from the causes and on the date stated above.											
22a. SIGNATURE L. G. Thorne				22b. PHYSICIAN'S NAME (Type) L. G. THORNE, LT, MC, USN				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22c. DATE SIGNED 3-16-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 3-18-61		23c. NAME OF CEMETERY OR CREMATORY Seaside Memorial Cemetery		23d. LOCATION (City, town or county) (State) Corpus Christi, Texas					
24. FUNERAL DIRECTOR'S SIGNATURE R.H. PUMPHREY				ADDRESS 1557 WISCONSIN Ave BETH.MD				25a. REC'D BY REGISTRAR MAR 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

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CERTIFICATE OF DEATH

Reg. Dist. No. 03206

1. PLACE OF DEATH o. COUNTY Montgomery Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DE. MD b. COUNTY PR. Goo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUSH-SILVER SPRING		c. LENGTH OF STAY IN 1b 17 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARLEA SANITARIUM		d. STREET ADDRESS 3702 36th ST 625 57th Ave. Cap. Hb.	
3. NAME OF DECEASED (Type or print) FLORA P. BEAVERS		4. DATE OF DEATH Month March Day 7 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 21 1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE	11. BIRTHPLACE (State or foreign country) WASH. DC.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME WILFORD NOTT	
14. MOTHER'S MAIDEN NAME AGNES ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or defense service) NONE	
16. SOCIAL SECURITY NO. UNKNOWN		INFORMANT EVERETT J. BEAVERS SA-625-57th Ave CAPITOL HILL, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 20, 1961 , to March 7, 1961 , that I last saw the deceased alive on March 7, 1961 , and that death occurred 8:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers		ADDRESS (Street, city or town, state) 1365 Spring Rd, Silver Spring, Md 20901	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS		DATE SIGNED 3-7-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/11/1961	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cem	22d. LOCATION (City, town, or county) (State) COLMAR MANOR PRGO Co, MD
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Chambers, Wash, D.C.		24a. REC'D BY REGISTRAR MAR 13 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3219 03207

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>8007 18th ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Beck</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>Cauc.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-60</u> 9. AGE (In years last birthday) <u>1</u> yrs. <u>8</u> months <u>13</u> days IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Robert S. Beck</u> 14. MOTHER'S MAIDEN NAME <u>Hora E. Emory</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or date of service) 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>admission Record</u> Address <u>Washington Sanitarium</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Congenital heart disease (Tetralogy of Fallot)</u> 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Dehydration</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> , 19 <u>60</u> to <u>3/5</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>61</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above.	
22a. SIGNATURE <u>Eino Magi</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>918 Univ. Blvd. E., Silver Spring, Md.</u> 22b. DATE SIGNED <u>3/6/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-7-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Prince George County, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Hall</u> ADDRESS <u>254 CARROLL ST. NW WASH. 12, D.C.</u> 25. REC'D BY REGISTRAR <u>DATE MAR 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Clara S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3220

03208

1. PLACE OF DEATH a. COUNTY <u>Wheaton Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Rockville</u> MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Maryland</u>		c. LENGTH OF STAY IN 1b <u>less than 1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>ALBIN</u> Last <u>BERNHARD</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 28, 1886</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heat Packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobin Packing Co. Albany, N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK BERNHARD</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-05-2300</u>	
17. INFORMANT <u>Wheaton Nursing Home</u>		Address <u>11901 Ga. Ave. Wheaton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Osteoarthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>? yrs</u> <u>? yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1960</u> to <u>March 19, 1961</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>March 18, 1961</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare</u>		22b. DATE SIGNED <u>3/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		22d. ADDRESS <u>7600 Carroll Ave. Tak. PK. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REGISTRAR'S SIGNATURE <u>William S. Krame</u>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

WERNER E. PUMPHREY, INC.
Raymond A. Ziska

SILVER SPRING, MD.

DATE MAR 23 61

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CERTIFICATE OF DEATH

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Blank certificate form with faint lines and text, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through from the reverse side.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3221

CERTIFICATE OF DEATH

03209

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNA ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8919 1st Avenue				d. STREET ADDRESS 02X-2			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle HENRY Last BIRCH				4. DATE OF DEATH Month March Day 8 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/21/01	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 8		IF UNDER 24 HRS. Hours 19 Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver - own cab				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JAMES A. BIRCH			
14. MOTHER'S MAIDEN NAME EMMA SPINKS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. 579-09-6154				17. INFORMANT Mrs. Goldie M. Nalley, 8919 1st Ave. Silver Spring, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 148X DUE TO Conditions, if any, which gave rise to immediate cause (b) Inanition (c) Carcinoma of pharynx DUE TO causa last.				INTERVAL BETWEEN ONSET AND DEATH 15 min 3 months 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Dec 19, 1960 to March 8, 1961 , that (I) (we) last saw the deceased alive on Feb 28, 1961 , and that death occurred at 6:35 AM , from the causes and on the date stated above.							
22a. SIGNATURE Jules I. Caman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 8, 1961	
22c. PHYSICIAN'S NAME (Type) JULES I. CAMAN				22d. ADDRESS 1015 SPRING ST. SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/11/61		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE MAR 14 '61	
25b. REGISTRAR'S SIGNATURE Julius E. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3222

03210

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN HOSPITAL <u>3/11/61 9:00 AM</u> <u>3/13/61 11:45 PM</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. STREET ADDRESS <u>13804 Wexford Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miriam B. Bishop</u>				4. DATE OF DEATH Month Day Year <u>3/13/1961</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/7/88</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>2 6</u>		IF UNDER 24 HRS. Hours Min. <u>2 6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Halifax Nova Scotia Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>							
13. FATHER'S NAME <u>Frederick W. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Boyd Rhind</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Thomas N. Sauer</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Carcinoma of sigmoid?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>C. perforation.</u> (b) (c)				INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/11/1961</u> to <u>3/13/61</u> , that (I) (we) last saw the deceased alive on <u>3/13/61</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. J. Brennan</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/13/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>				22d. ADDRESS <u>Bethesda, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 16 61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

03240

3252

(M)

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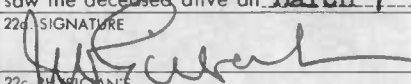
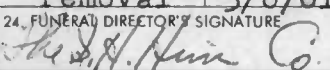
Robert A. Langhrey
Bethesda, Maryland
3/10/61
Rock Creek Cemetery
Washington, D. C.
Clerk & Nurse
Mar 10 61

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03211

3223

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Point Pleasant			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 282 Sudbury Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Edward		Middle (None)		Last Blecker	
4. DATE OF DEATH		Month March		Day 7		Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1906		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 54	IF UNDER 24 HRS. Days 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Frameman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Blecker				14. MOTHER'S MAIDEN NAME Frances Hertwig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 139-09-7175		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation, Intra-Operative DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Aortic Valve Incompetency DUE TO (c) Rheumatic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 30 Minutes Years Since Childhood
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 5, 1961 to March 7, 1961 , that (I) (we) last saw the deceased alive on March 7, 1961 , and that death occurred at 12:55 am from the causes and on the date stated above.							
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-8-61			
22c. PHYSICIAN'S NAME (Type) J. W. GILBERT, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 3/8/61		23c. NAME OF CEMETERY OR CREMATORY Graceland Mem. Park Cem.		23d. LOCATION (City, town, or county) (State) Kenilworth, N.J.	
24. FUNERAL DIRECTOR'S SIGNATURE 		25a. REC'D BY REGISTRAR Wash 9, D.C.		25b. REGISTRAR'S SIGNATURE Curious S. Hume		25c. DATE MAR 10 '61	

MEDICAL CERTIFICATION

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67X-3

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CERTIFICATE OF DEATH

First Name

John Thomas

Age

62

The Medical Center, Bethesda, Md.

Sex

(M)

Date of Birth

1908

White

Male

Address

Telephone No.

Signature

Henry Jackson

Date

100-10-100

The Medical Center, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3224
03212
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 10550 MacArthur Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle F. Last Bodine				4. DATE OF DEATH Month March Day 12 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1879	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bodine				14. MOTHER'S MAIDEN NAME Elizabeth Stone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 months						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 15, 1961 , to March 12, 1961 , that (I) (we) last saw the deceased alive on March 12, 1961 , and that death occurred at 12:50 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Robert B. Scoggins				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/13/61	
22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 16 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. House			

U.S. DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

1934

05823

Name of deceased		Sex		Age	
John Doe		Male		35 years	
Date of death		Place of death		Cause of death	
March 22, 1934		New York City		Heart disease	
Usual residence		Place of birth		Date of birth	
New York City		New York City		March 22, 1899	
U.S.A.		U.S.A.		U.S.A.	
Signature of physician		Signature of registrar		Signature of informant	
[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		Signature of registrar	
March 22, 1934		New York City		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3225
CERTIFICATE OF DEATH
03213

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4501 Gretna Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Frederick BOHN		4. DATE OF DEATH Month March Day 1 Year 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-81	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grain Buyer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (County & State, or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick BOHN		14. MOTHER'S MAIDEN NAME Henrietta JANN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. (S) Capt. C.L. Bohn, DC, USN, same as #2 above	
17. INFORMANT (S) Capt. C.L. Bohn, DC, USN, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, bronchogenic C Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 16, 1961 to March 1, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 1, 1961 and that death occurred at 12:35 PM from the causes and on the date stated above.			
22a. SIGNATURE Russell Miller, Jr. - LT (MC) USN M.D.		22b. DATE SIGNED 3-1-61	
22c. PHYSICIAN'S NAME (Type) Russell MILLER, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 3-2-61	
23c. NAME OF CEMETERY OR CREMATORY Frankfort Cemetery		23d. LOCATION (City, town or county) (State) Frankfort So. Dakota	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Tyson Wheeler Funeral Home, Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAR 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3226
CERTIFICATE OF DEATH

05214

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 1 yr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1300 COLESVILLE-BELTSVILLE ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 1300 COLESVILLE-BELTSVILLE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle E. Last BOWMAN		4. DATE OF DEATH Month MARCH Day 1 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/88
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 10 Days 15	IF UNDER 24 HRS. Hours 3 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. KING		14. MOTHER'S MAIDEN NAME CORA V. CRUMP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Bessie King, 1300 Colesville-Beltsville Rd. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Heart Disease 443 X DUE TO (b) Atherosclerosis Generalized Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) Fracture Left Hip		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 yrs 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cerebral Thrombosis - partial Right Hemiplegia (7 yrs)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour 5:45 e.m. 3-4-61 p.m. AM 19 61		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 1, 1961		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1961 to March 1, 1961 , that (I) (we) last saw the deceased alive on March 1, 1961 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Kenneth F. Laughlin		22b. DATE SIGNED March 1-1961	
22c. PHYSICIAN'S NAME (Type) KENNETH F. LAUGHLIN		22d. ADDRESS 934 Ellsworth Dr., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/4/61	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Giska		25a. REC'D BY REGISTRAR MAR 8 '61	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3227 Item 2 Film 6205 3/25/61 1wk
CERTIFICATE OF DEATH

03215

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>20</u> <u>Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8865 Piney Branch Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth Emma Bratburd</u>				4. DATE OF DEATH <u>March 15,</u> <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1899</u>	
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Gustave Baumbach</u>				14. MOTHER'S MAIDEN NAME <u>Virginia ? ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Eddie Bratburd</u>		17. INFORMANT <u>8865 Piney Branch Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pulmonary Edema</u> DUE TO <u>155.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Partial Obstruction</u> DUE TO (c) <u>Carcinoma of Gall Bladder</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u> <u>3 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>60</u> , to <u>3/15</u> , 19 <u>61</u> , that (I) (was) last saw the deceased alive on <u>3/14</u> , 19 <u>61</u> , and that death occurred at <u>2:14</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis X. Richardson</u>				22b. DATE SIGNED <u>3/16/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Francis X. Richardson</u>				22d. ADDRESS <u>11412 Viers Mill Rd. Wheaton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 16, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	
23d. LOCATION (City, town, or county) (State) <u>Prince Georges Co., Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>MAR 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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CERTIFICATE OF DEATH

2337

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CHIEF CLERK

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEYNSVILLE				c. LENGTH OF STAY IN 1b 2 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle SYLVESTER Last BRIGHT				4. DATE OF DEATH Month MARCH Day 2 Year 19 61			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 2, 1961	
9. AGE (In years last birthday) 2		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MONTGOMERY COUNTY	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME SHEILA LEE BRIGHT				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 2 lb 12 oz. 762.5 2hr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. atelectasis of lungs 2hr DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/2 1961 19 3/2 61 , that (I) (we) last saw the deceased alive on 3/2 1961 , and that death occurred 2:30 PM from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 3/3/61			
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/4/61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				25a. REC'D BY REGISTRAR DATE MAR 20 '61		25b. REGISTRAR'S SIGNATURE [Signature]	

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CERTIFICATE OF DEATH

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MONTGOMERY

MONTGOMERY

DEATH OF A PERSON WHOSE DEATH WAS NOT REPORTED TO THE HEALTH DEPARTMENT

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MONTGOMERY COUNTY

DEATH OF A PERSON WHOSE DEATH WAS NOT REPORTED TO THE HEALTH DEPARTMENT

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DEATH OF A PERSON WHOSE DEATH WAS NOT REPORTED TO THE HEALTH DEPARTMENT

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03217

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MASS.</u> b. COUNTY <u>Middlesex</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>REVERE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. St + Hosp.</u>				d. STREET ADDRESS <u>51 Highland St</u>			
3. NAME OF DECEASED (Type or print) <u>Sarah Brooks</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-90</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Roumania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Roumanian</u>	
13. FATHER'S NAME <u>HARRY GREENBERG</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. Samuel Brooks</u> Address <u>Same as deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO (b) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Blaschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLASCHERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-26-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>MARCH 28, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TIFARETH ISRAEL CEMETERY</u>	
				22d. LOCATION (City, town, or country) <u>EVERETT</u>		(State) <u>MASS</u>	
23. FUNERAL DIRECTOR <u>B. J. J. J. J.</u>				ADDRESS <u>3501-14th Ave</u>		24a. REC'D BY REGISTRAR	
				DATE <u>MAR 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>	

MEDICAL CERTIFICATION

1921

CERTIFICATE OF DEATH

THE STATE
DEPARTMENT OF HEALTH

(M)

(I)

[Faint, mostly illegible text of the certificate form, including fields for name, age, sex, date of death, and cause of death.]

VS. AISME
5M 7/59

03218

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 127 EASTMOOR DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD BROOKS		4. DATE OF DEATH Month MARCH Day 19 Year 1961	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/1/90	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES E. BROOKS		14. MOTHER'S MAIDEN NAME MOLLIE WYLIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-22-1916	
17. INFORMANT Mrs. Margaret M. Brooks, 127 Eastmoor Dr. Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/21/61 Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/22/61	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or country) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR WASNER E. BUMPNEY, INC. <i>Raymond A. Ziska</i>		24a. REC'D BY REGISTRAR MAR 23 '61	
24b. REGISTRAR'S SIGNATURE <i>William E. Howard</i>		25. ADDRESS SILVER SPRING, MD.	

THE STATE
OF NEW YORK

IN SENATE
JANUARY 1, 1910

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DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

REPORT OF THE REGISTRAR
ON THE VITAL STATISTICS
FOR THE YEAR 1909

ALBANY, N. Y.: 1910

PRINTED BY THE STATE PRINTING OFFICE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3231

03219

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓ <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>3604 Upshur St</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Winfield Brown</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/23/85</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Government Printing Office</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D. C.</u>			
13. FATHER'S NAME <u>Scott Winfield Brown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Wife - Mrs. Caroline Brown - Same</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Artery (Heart) Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>4 hrs.</u> <u>9 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1952</u> to <u>Mar 22 1961</u> , that (I) two last saw the deceased alive on <u>Mar 22 1961</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert B. Tiley</u>				22b. DATE SIGNED <u>Mar 22, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. TILLEY</u>	
22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Antony Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

Enc.

1931

CERTIFICATE OF DEATH

5331

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon page 3 and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3232
CERTIFICATE OF DEATH
03220

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croftersburg</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>1 R.F.D. #3-Watkins Mill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Matie Jane Campbell</u>				4. DATE OF DEATH <u>March 30 1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/1/1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework & cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Washington</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Long</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Ella Offutt-Croftersburg, Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency, acute</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular renal disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Uremia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		Month, Day, Year 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that the (this hospital) attended the deceased from <u>3/30/61</u> , 19 <u>61</u> , to <u>3/30/61</u> , 19 <u>61</u> , that the (we) last saw the deceased alive on <u>3/30/61</u> , 19 <u>61</u> , and that death occurred at <u>7:25</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert N. Coale</u>				M.D.		22b. DATE SIGNED <u>3/31/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>				22d. ADDRESS <u>4630 Montgomery Ave. Bethesda Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>		23d. LOCATION (City, town or county) (State) <u>Laytonville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville Md.</u>		25a. REC'D BY REGISTRAR <u>APR 7 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and return it to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3233

03221

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>303 Woodland Rd.</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl Elsie Carter</u>		4. DATE OF DEATH <u>March 16 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/05</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>29</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school bus driver Board of Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elsby Carter</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Carter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes Unknown</u>	
17. INFORMANT <u>Pearl L. Carter / wife</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (b) <u>Essential Hypertension</u> (a), stating the underlying cause last, DUE TO (c) <u>CORONARY ARTERY DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>10 min -</u> <u>104 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 13 1956</u> to <u>MARCH 16 1961</u> , that (I) (we) last saw the deceased alive on <u>MARCH 16 1961</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D.		22b. DATE SIGNED <u>17 MAR 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger, M. D.</u>		22d. ADDRESS <u>310 W. Montgomery Ave, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Darnestown, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1888

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(M)

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John A. Roseberry, Jr. 10. 10. 1888

Robert A. Rumphey, Bethesda, Maryland
Dorchester Cemetery, Dorchester, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VP A15 (4)
15M 9/59

3234
MONTGOMERY MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03222

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6612 ALLEGHENY AVE.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>6612 ALLEGHENY AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>F.</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 8, 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE COUNTY, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DAVIS CARTER</u>		14. MOTHER'S MAIDEN NAME <u>LILLIE FORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. LOTTIE C. CARTER</u>		Address <u>6612 ALLEGHENY AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the right lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis & emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September 6, 1961</u> to <u>March 26, 1961</u> that (I) (we) last saw the deceased alive on <u>March 24, 1961</u> and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jason Geiger</u>		22b. DATE SIGNED <u>3-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>		22d. ADDRESS <u>110 SPRING STREET SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>MAR. 29, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CHURCH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>FOREST GLEN, MONTGOMERY CO., MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kenna</u>		ADDRESS <u>WASH. D.C.</u>	
25a. REC'D BY REGISTRAR <u>Arthur S. Kenna</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	
DATE <u>MAR 29 '61</u>			

1
FOR STATE
HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>4 mo</u>		d. STREET ADDRESS <u>15th St. S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ropin Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucy Casey</u>		4. DATE OF DEATH <u>Mar 27 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>SUGAR NOTCH, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McNamee</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tracy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Record</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO (b) <u>Fracture Rt hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - months</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor in Nursing Home</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 a.m. 3-1-1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) <u>Rockville Maryland</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 27-1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/29/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ASHLEY, PENNA.</u>	
23. FUNERAL DIRECTOR <u>MARTIN W. HYSONG CO. 1300 N. STREET, N.W.</u>		ADDRESS <u>WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>MAR 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1933

2332

UNITED STATES
DEPARTMENT OF
HEALTH
(M)

U.S.S. 1000
SUGAR HILL, N.Y.

(1)

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D.C.
JANUARY 1, 1934

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3236

CERTIFICATE OF DEATH

03224

Item 12 Film G285 4/17/61

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md. c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Stinking Gardens		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE 110- E. Street N.W. b. COUNTY Washington D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS 110-E. Street N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) May T. Cerceo		4. DATE OF DEATH Month Day Year March 15, 1961 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2-1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Yasaelli		14. MOTHER'S MAIDEN NAME Erminia Falcone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Josephine Grove-daughter		Address 110- E. St. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conjunctive Heart FAILURE DUE TO (b) Arteriosclerosis - Renal DUE TO (c) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks yes yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/15/61 to 3/15/61 , that (I) (we) last saw the deceased alive on 3/15/61 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE SAM ALLEN, M.D. Kensington, Maryland		22b. DATE SIGNED 3/15/61	
22c. PHYSICIAN'S NAME (Type) SAM ALLEN, M.D. Kensington, Maryland		22d. ADDRESS 110- E. Street N.W.	
23a. BURIAL, CREMATION, or other disposal (Specify) 3/18/61		23b. DATE OF BURIAL, CREMATION, or other disposal 3/18/61	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE J.Wm. Lee's Sons Co.		ADDRESS 300-4th St. N.E.	
25a. REC'D BY REGISTRAR MAR 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



2000

George Xue 0111

No. 0111

Sanitary
Chlorine - 1/2 lb
1/2 lb

1/2 lb 1/2 lb



2/1/10
Sanitary
Chlorine
1/2 lb

1/2 lb 1/2 lb

1/2 lb 1/2 lb

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
3237
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03225

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4408-WALSH STREET		d. STREET ADDRESS 4408 WALSH STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAURA TENNANT CHUBB		4. DATE OF DEATH Month Day Year MARCH 24 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 18, 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GOELLA TENNANT		14. MOTHER'S MAIDEN NAME ELLA ADEL DICKERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT MRS. ERNESTINE QUINN - 4408 WALSH ST.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ventricular Failure DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO 20yr (c) 20yr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1952 to March 24, 1961 , that (I) (we) last saw the deceased alive on 3/23 19 61 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm Fleet Luckett		22b. DATE SIGNED 3-24-61	
22c. PHYSICIAN'S NAME (Type) Wm Fleet Luckett		22d. ADDRESS 5000 IRING RD NW DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3-24-1961	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol		25a. REC'D BY REGISTRAR 27 '61	
ADDRESS 2224-Wis. Ave. N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

0323

RECEIVED

0323

(1)

(1)

CERTIFICATE OF DEATH

Reg. Dist. No.

03226

2238

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring.,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Sandy Spring, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1 Brooke Rd			
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Claggett				4. DATE OF DEATH Month March Day 14 Year 19 61			
5. SEX male	6. COLOR OR RACE A A	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6 1882		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marshall Claggett				14. MOTHER'S MAIDEN NAME Leanna Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Alice E. Claggett Address Brooke Road., Sandy Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorenal Disease with Edoema 260X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Diabetes Mellitus (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bubobocoele. Bronchial Asthma. Auricular Fibrillation.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 25 , 19 58 , to March 15 , 19 61 , that I last saw the deceased alive on March 14 , 19 61 , and that death occurred at 1:12 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Webster Sowell				M.D. Norbeck Rt. 1 Silver Spring, 3/17/61			
PHYSICIAN'S NAME (Type) Webster Sowell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/61		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				24a. REC'D BY REGISTRAR DATE MAR 23 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3239

CERTIFICATE OF DEATH

03227

Item 2 Film G284 4/13/61 iwk

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JACKSON TARK</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>CALIFORNIA</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring MD</u> d. STREET ADDRESS <u>OLD STAR MOTELS HOME 809 Apple Road 259 N. Euclid</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Emma Ann Clemmer</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/21/92</u>		
9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private duty</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Oklahoma</u>	
13. FATHER'S NAME <u>William Howard</u>		14. MOTHER'S MAIDEN NAME <u>Martha Shipman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>554-22-1496</u>		17. INFORMANT <u>p/t Hospital record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic coronary insufficiency</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 d.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arterio aneurysm</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-24</u> , 19 <u>61</u> , to <u>3-25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-24</u> 19 <u>61</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Abraham W. Danish</u>		22b. DATE SIGNED <u>3-25-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>		22d. ADDRESS <u>927 PERSHINS DR SILVER SPRING</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon page 3 and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

1958

2500

RECEIVED

DATE

TIME

BY

FOR

1958-1-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and 5 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3240

03228

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 110 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 5808 Cedar Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Calvin Hayes COBB		4. DATE OF DEATH March 29 19 61			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-89	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Maine	
13. FATHER'S NAME George W. Cobb		14. MOTHER'S MAIDEN NAME Alberta Hayes		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1907 to 1946		16. SOCIAL SECURITY NO. 220-34-3661		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pelvic Bone, and probably 177X DUE TO Central nervous system metastases Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO Carcinoma of the prostate (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County)		20g. (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 9 1960 to March 29, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 29 1961, and that death occurred at 7:58 PM, from the causes and on the date stated above.					
22a. SIGNATURE H. S. IRONS, LT, MC, USN		22b. DATE SIGNED 3-30-61		22c. PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
24. FUNERAL DIRECTOR'S SIGNATURE Gawlers Funeral Home, 1756 Pa. Ave., NW, WashDC		24b. REC'D BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

3230

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03229

3241

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b X SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME				d. STREET ADDRESS 3710 NIMITZ ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle LYLE Last COINER				4. DATE OF DEATH Month MARCH Day 14 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/29/82	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Express Clerk				10b. KIND OF BUSINESS OR INDUSTRY Seaboard Airline RR		11. BIRTHPLACE (State or foreign country) Waynesboro, Virginia	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Casper Coiner				14. MOTHER'S MAIDEN NAME Hannah Rebecca Coiner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 714-16-3346		17. INFORMANT Address Mrs. Carrie L. Coiner, 9202 Sudbury Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Congestive Heart FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerosis generalized (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH 1-2 weeks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/7/60 , 19 60 , to 3/14/61 , 19 61 , that I last saw the deceased alive on 3/14 , 19 61 , and that death occurred at 12:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SAM ALLEN, M.D. Kensington, Maryland DATE SIGNED							
ACTUAL SIGNATURE SAM ALLEN M.D.				M.D.			
PHYSICIAN'S NAME (Type) SAM ALLEN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/18/61		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond E. Piska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 20 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. STREET ADDRESS		10. CITY		11. COUNTY		12. STATE	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. CAUSE OF DEATH	
17. MEDICAL HISTORY		18. PRESENT ILLNESS		19. TREATMENT		20. PHYSICIAN'S SIGNATURE	
21. CORONER'S SIGNATURE		22. BURIAL PLACE		23. DATE OF BURIAL		24. BURIAL TIME	
25. OTHER SIGNATURES		26. OTHER SIGNATURES		27. OTHER SIGNATURES		28. OTHER SIGNATURES	

THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD., HAS RECEIVED THE FOLLOWING REPORT OF DEATH:

NAME OF DECEASED: [Name]

SEX: [Sex]

AGE: [Age]

DATE OF BIRTH: [Date]

PLACE OF BIRTH: [Place]

OCCUPATION: [Occupation]

MARITAL STATUS: [Status]

COLOR: [Color]

STREET ADDRESS: [Address]

CITY: [City]

COUNTY: [County]

STATE: [State]

DATE OF DEATH: [Date]

TIME OF DEATH: [Time]

PLACE OF DEATH: [Place]

CAUSE OF DEATH: [Cause]

MEDICAL HISTORY: [History]

PRESENT ILLNESS: [Illness]

TREATMENT: [Treatment]

PHYSICIAN'S SIGNATURE: [Signature]

CORONER'S SIGNATURE: [Signature]

BURIAL PLACE: [Place]

DATE OF BURIAL: [Date]

BURIAL TIME: [Time]

OTHER SIGNATURES: [Signatures]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
3242
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03230

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY d. STREET ADDRESS WOODLAWN FARM e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES EARL COLBERT JR.		4. DATE OF DEATH Month Day Year MARCH 12 1961	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/12
9. AGE (In years lost birthday) 48		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES COLBERT		14. MOTHER'S MAIDEN NAME MATTIE WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Acute cardiac failure DUE TO (c) Extensive bilateral bronchial pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hours 48 hours 10 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/3/61 to 3/12/61 , that (I) (we) last saw the deceased alive on 3/12/61 and that death occurred at 9:50 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker		22b. DATE SIGNED 3/13/61	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.		22d. ADDRESS CLARKSVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-16-61	
23c. NAME OF CEMETERY OR CREMATORY St. Louis		23d. LOCATION (City, town, or county) (State) Clarks ville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C.Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR DATE MAR 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

MISSOURI DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
CERTIFICATE OF DEATH

11-13-31

NAME: CHARLES
AGE: 52
SEX: M
DATE OF BIRTH: 11-13-31
PLACE OF BIRTH: IOWA
OCCUPATION: FARMER
CAUSE OF DEATH: HEART DISEASE
PLACE OF DEATH: IOWA
DATE OF DEATH: 11-13-31
SIGNATURE: [Signature]
DATE: 11-13-31

At the County of [County] State of [State]
I, [Name], Clerk of the County, do hereby certify that the foregoing is a true and correct copy of the original record on file in my office.

Witness my hand and the seal of the County at [Location] this [Date] day of [Month] 1931.

[Signature]
Clerk of the County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3243

CERTIFICATE OF DEATH

Reg. Dist. No.

03231

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4858 Battery Lane				d. STREET ADDRESS 4858 Battery Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alice Middle Cramer Last Cramer				4. DATE OF DEATH Month March Day 4 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1881	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 4 Days 0 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Winfield S. Epler				14. MOTHER'S MAIDEN NAME Mary Cunningham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William E. Cramer, Jr.--Son-Bethesda, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary heart disease, congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) 				INTERVAL BETWEEN ONSET AND DEATH 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from Feb 15, 1961 , to March 4, 1961 , that I last saw the deceased alive on March 3, 1961 , and that death occurred at 10:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Joseph Kenrick				DATE SIGNED 6450 Wisc. Ave. Bethesda, Md. 3/4/61			
PHYSICIAN'S NAME (Type) DR. JOSEPH KENRICK				6450 Wisc. Ave. Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/61		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 8 '61	
				24b. REGISTRAR'S SIGNATURE 			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1600 block Overlook Dr.</u>					d. STREET ADDRESS <u>1315 7th St. N.W.</u>				
3. NAME OF DECEASED (Type or print) <u>Landurn</u> <u>Curtis</u>					4. DATE OF DEATH Month <u>Mar.</u> Day <u>18</u> Year <u>1961</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/12/1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Jerry Curtis</u>					14. MOTHER'S MAIDEN NAME <u>✓</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Police record</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>925.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Sewer ditch cave-in</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of pelvis and 8th rib (rt)</u>									
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Excavating a trench for sewer. Cave in</u>							
20c. TIME OF INJURY Month, Day, Year <u>2:45 p.m.</u> <u>3/18/61</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>building project</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3/19/61</u>							
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		22d. LOCATION (City, town, or country) (State) <u>Md.</u>			
23. FUNERAL DIRECTOR <u>W. H. Bacon 1722 7th St. N.W.</u>					24a. REC'D BY REGISTRAR <u>MAR 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03253

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash SAN + Hosp</u>				d. STREET ADDRESS <u>1420 East West Hwy</u>			
3. NAME OF DECEASED (Type or print) <u>Lawrence Walker Dalton</u>				4. DATE OF DEATH <u>3-15-61</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-05</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Business Mach</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Dalton</u>				14. MOTHER'S MAIDEN NAME <u>Georgie Walker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>265-01-9543</u>		17. INFORMANT <u>Mrs Rae Dalton - Same deceased</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> 420.1 DUE TO (b) <u>LEFT CORONARY SCLEROSIS, SEVERE</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>RIGHT CORONARY OCCLUSION, OLD.</u> DUE TO (c) <u>ASPIRATION OF STOMACH CONTENT</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-16-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Fredericksburg, Virginia</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03234											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 22 hrs.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Roy L. Davies						4. DATE OF DEATH March 18 19 61					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 1899 2/24/99					
9. AGE (In years last birthday) 62 yrs.						10. IF UNDER 1 YEAR Months 1 Days 16					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired						10b. KIND OF BUSINESS OR INDUSTRY Electriaal					
11. BIRTHPLACE (County & State, or foreign country) Scranton, Pa.						12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Thomas G. Davies						14. MOTHER'S MAIDEN NAME Harriet Davis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. Yes Unknown					
17. INFORMANT Wife Mrs. Ruth Davies						17. ADDRESS Same as above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA LIVER 151X DUE TO And OMENTUM, ESOPHAGUS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PRIMARY CARCINOMA STOMACH. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 9 mos.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19											
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 7/2/57 , 19....., to 3/18/61 , 19....., that (I) was last saw the deceased alive on 3/17/61 , 19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE J. Blaine Fitzgerald M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED 3/18/61											
22c. PHYSICIAN'S NAME (Type) J. BLAINE FITZGERALD											
22d. ADDRESS 8218 WISCONSIN AVE. BETHESDA.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 3/20/61											
23b. DATE THEREOF 3/20/61											
23c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery											
23d. LOCATION (City, town or county) (State) Moscow, Pennsylvania											
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland											
25a. REC'D BY REGISTRAR MAR 21 '61											
25b. REGISTRAR'S SIGNATURE Carlton L. Hester											



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Staphania Hospital

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John

U.S.A.

Thomas. David

Thomas. David

Yes

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John. With David. Same as above

Butter-Transit 2/20/01 Moscow Cemetery

Butter-Transit 2/20/01 Moscow Cemetery

Butter-Transit 2/20/01 Moscow Cemetery

Butter-Transit 2/20/01 Moscow Cemetery

BALTIMORE, 18

3247

CERTIFICATE OF DEATH

Reg. Dist. No. **03235**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 6221 Tilden Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Claude Middle L Last Davis				4. DATE OF DEATH Month March Day 10 Year 19 61			
5. SEX Male		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 17, 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Myrtle V. Davis 6221 Tilden Lane., Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary heart disease c hypertension DUE TO (c) arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 hr. 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 28 , 19 55 , to 10 Mar. , 19 61 , that I last saw the deceased alive on 7 Mar. , 19 61 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7801 Norfolk Avenue DATE SIGNED 3/15/61							
ACTUAL SIGNATURE <i>John M. Wyman</i>				PHYSICIAN'S NAME (Type) John M. Wyman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/15/61		22c. NAME OF CEMETERY OR CREMATORY Oak Grove..	
22d. LOCATION (City, town, or county) Mt. Zion, Md.				24a. REC'D BY REGISTRAR DATE MAR 20 '61			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				24b. REGISTRAR'S SIGNATURE <i>Robert L. Snowden</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3248

03236

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 721 DALE DRIVE				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 721 DALE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELSIE C. DAVIS		4. DATE OF DEATH Month MARCH Day 27 Year 19 61					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/27/73	9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) BURLINGTON, IOWA			
13. FATHER'S NAME GEORGE P. CARPENTER			14. MOTHER'S MAIDEN NAME ELLA HARMON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Edwin C. Davis, 721 Dale Drive Address Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sclerosing Carcinoma, Right Breast DUE TO (b) Metastasis to Dorsal Spine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) SILVER SPRING	(County) PRINCE GEO. COUNTY	(State) MARYLAND		
21. I certify that (I) (the hospital) attended the deceased from April 25, 1960 to March 27, 1961 , that (I) (we) last saw the deceased alive on March 25, 1961 , and that death occurred at 1:55 PM , from the causes and on the date stated above.							
22a. SIGNATURE Merrill M. Cross M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/27/61			
22c. PHYSICIAN'S NAME (Type) MERRILL M. CROSS M.D.		22d. ADDRESS 8248 GEORGIA AVE SILVER SPRING MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3/27/61		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Giska		ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR APR 3 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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FOR STATE HEALTH DEPT. (M)
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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Erie</u> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>3 mo</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Erie</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10705 Huntley Place</u>				d. STREET ADDRESS <u>657 East 31 st.</u>			
3. NAME OF DECEASED (Type or print) <u>Nellie REGINA Davis</u>		First Middle Last		4. DATE OF DEATH <u>Mar 28 1961</u>		Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-9-1895</u>	
9. AGE (in years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Humphrey</u>				14. MOTHER'S MAIDEN NAME <u>Susan Wise</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Shirley Mahon - Sister</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>subseq</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>Mar 28-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<u>TRANS. & BURIAL</u>		<u>4/3/61</u>		<u>CALVARY CEMETERY</u>		<u>ERIE, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
24e. REC'D BY REGISTRAR <u>APR 3 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03238

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY in 1b <u>3 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. SAN + Hosp</u>			d. STREET ADDRESS <u>1441 Spring Rd, NW</u>		
3. NAME OF DECEASED (Type or print) <u>ROBERT Allan Davis</u>			4. DATE OF DEATH <u>3-12-1961</u>		
5. SEX <u>m</u>			6. COLOR OR RACE <u>Cauc</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9-12-42</u>		
9. AGE (In years last birthday) <u>18 yrs.</u>			10. IF UNDER 1 YEAR Months Days		
11. IF UNDER 24 HRS. Hours Min.			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Usber - Tool, Theater</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
13. FATHER'S NAME <u>James Davis</u>			14. MOTHER'S MAIDEN NAME <u>Irene Mayes</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>(If yes give number or dates of service)</u>		
17. INFORMANT <u>Mother - Mrs Irene Davis</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Fracture of skull</u> DUE TO (c) <u>Bullet wound in skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Playing Russian Roulette + shot self in head</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:00 p.m. 3-9 1961</u>					
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>					
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1605 Bonifant Rd Silver Spring montg Md</u>					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <u>3-12-61</u>					
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>3/15/61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>					
22d. LOCATION (City, town, or country) (State) <u>Prince Georges Co. Md.</u>					
23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>					
24a. REC'D BY REGISTRAR <u>MAR 14 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>					

MEDICAL CERTIFICATION

100-2117

3250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-2117

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03239

3251

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 12, Md. c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 200 E. Franklin Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs. MAY LOUISE DAYTON		4. DATE OF DEATH Last Month Day Year March 6, 1961		5. SEX Female			
6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-29-02			
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME Transfer & Storage Co.		11. BIRTHPLACE (County & State, or foreign country) District of Columbia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Yulee Hodges					
14. MOTHER'S MAIDEN NAME Edith Keniston		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. 578-03-2196		17. INFORMANT Patients Chart					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma to lungs DUE TO (c) Adenocarcinoma of both breasts							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic carcinoma to long + short bones - pathological fracture, rt. hip + ribs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Prince George County, MD.		20g. (County) Prince George County, MD.					
21. I certify that (I) (this hospital) attended the deceased from 2-24, 1947 to 3-6, 1961 , that (I) (we) last saw the deceased alive on March 6, 1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Benjamin Isaacson, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/6/61			
22c. PHYSICIAN'S NAME (Type) Benjamin Isaacson, MD		22d. ADDRESS 7733 Alaska Ave., N.W.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/9/61		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY			
23d. LOCATION (City, town or county) PRINCE GEORGE COUNTY, MD.		23e. (State) MD.					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.		ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR MAR 10 '61			
25b. REGISTRAR'S SIGNATURE Charles S. Thoms		25c. REGISTRAR'S NAME Charles S. Thoms					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1933

1933



1

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some discernible fragments include:

- Top left: "1933"
- Top right: "1933"
- Center: "Competitive Market Failure"
- Bottom left: "1933"
- Bottom right: "1933"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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M
3252
CERTIFICATE OF DEATH
03240

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>910 Newhall Street</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>910 Newhall Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD DELAMAISSON</u> First Middle Last				4. DATE OF DEATH <u>March 26</u> 19 <u>61</u> Month Day Year									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Switzerland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward M. Delamaison</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Louise Ponnai</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If any give war or dates of service)		17. INFORMANT <u>Mrs. Helen K. Delamaison (Same as #2)</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X Congestive Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>Six Mos.</u> <u>7 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1961</u> to <u>March 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 26, 1961</u> , and that death occurred at <u>11:50 P.</u> M., from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert A. Hare</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 27, 61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>				22d. ADDRESS <u>7600 Carroll Ave. T. Park, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 29, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) <u>Washington</u>		(State) <u>D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hare</u>				ADDRESS <u>254 Carroll St. N.W. DC</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>			
				DATE <u>MAR 28 '61</u>									

08220

2222

(M)

(I)

1957

Feb

Memorandum

Two pages

See Campbell's Test M.

Robert A. Hays, MD

MAY 8 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03241

3253

1. PLACE OF DEATH. a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b 1 yr	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown		d. STREET ADDRESS X	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Marylander Home of Rest		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Derosia Last Mar 25th		4. DATE OF DEATH Month 19 Day 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 18-1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 3 Days 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY "	
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Groark		14. MOTHER'S MAIDEN NAME Bridget McCormack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Derosia. Arlington. Va.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 10, 1961 to March 25, 1961 , that (I) (we) last saw the deceased alive on March 22, 1961 , and that death occurred at 9:45 PM from the causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED March 24, 1961	
22c. PHYSICIAN'S NAME (Type) James P. Kerr		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-61	
23c. NAME OF CEMETERY OR CREMATORY Glenwood		23d. LOCATION (City, town or county) (State) Watertown N. Y.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		25a. REC'D BY REGISTRAR MAR 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

3254
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03242

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 30 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 405 Thayer Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Edwin Dieste		4. DATE OF DEATH Month Day Year March 6 1961					
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1904	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Pepero		11. BIRTHPLACE (State or foreign country) District of Columbia U.S.A.			
13. FATHER'S NAME WILLIAM F. DIESTE			14. MOTHER'S MAIDEN NAME Elizabeth Spengler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-09-3928		17. INFORMANT Address Washington Sanitarium and Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433-1 Arricular Fibrillation & Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Cirrhosis of Liver (c) Diabetes mellitus Chronic Nephritis & Uremia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteo Arthritis, Bilateral, hip joints INTERVAL BETWEEN ONSET AND DEATH 4 mos Undetermined Undetermined Undetermined							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1960 to Mar 6, 1961 , that (I) (we) last saw the deceased alive on Mar 5, 1961 , and that death occurred at 11 AM , from the causes and on the date stated above.							
22a. SIGNATURE George L Ball		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar 6, 1961			
22c. PHYSICIAN'S NAME (Type) George L Ball		22d. ADDRESS 10629 Georgia Ave Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3/8/61		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY			
23d. LOCATION (City, town, or county)		23e. (State) PRINCE GEO COUNTY, MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond W. Humphrey		ADDRESS Humphrey, Inc. Silver Spring, Md		25a. REC'D BY REGISTRAR MAR 10 '61			
25b. REGISTRAR'S SIGNATURE Arthur L. Evans							

CENTRAL CASE OF HEALTH

1934

1. Name of patient: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Date of admission: [illegible]
5. Date of discharge: [illegible]
6. Place of birth: [illegible]
7. Occupation: [illegible]
8. Education: [illegible]
9. Marital status: [illegible]
10. Family size: [illegible]
11. Social history: [illegible]
12. Medical history: [illegible]
13. Physical examination: [illegible]
14. Laboratory tests: [illegible]
15. Pathological findings: [illegible]
16. Treatment: [illegible]
17. Prognosis: [illegible]
18. Remarks: [illegible]

1. PLACE OF DEATH o. COUNTY		MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		MARYLAND		b. COUNTY		MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		OLNEY		c. LENGTH OF STAY IN 1b		7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS		4818 DELRAY AVENUE		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MACK		Middle McCLINTON		Last ECKENRODE		4. DATE OF DEATH		Month MARCH		Day 31, Year 19 61	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-1880		9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOSEPH ECKENRODE		14. MOTHER'S MAIDEN NAME ADA HONOR											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neemia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yr</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> 19 <u>55</u> , to <u>March 31</u> , 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>March 31</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> P. M., from the causes and on the date stated above.		22a. SIGNATURE <u>A. D. Bonifant</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-31-61							
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS SANDY SPRING, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE APR 5 '61		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

101

3253

CERTIFICATE OF DEATH

0-253

HARTFORD

HARTFORD

OLNEY

7 DAYS

NEW YORK

HARTFORD GENERAL HOSPITAL

HARTFORD GENERAL HOSPITAL

MALE

JOSEPH A. SCHEER

HARTFORD

WHITE

1-1-1900

30

ELEVATOR WORKER

MARYLAND

JOSEPH A. SCHEER

HARTFORD

MALE

HARTFORD GENERAL HOSPITAL

Joseph A. Scheer

Joseph A. Scheer

1-1-1900

1-1-1900

Joseph A. Scheer

GARY - RING, HARTFORD

H. D. BURTON, N. D.

HARTFORD, CONNECTICUT

HARTFORD, CONNECTICUT

3256

CERTIFICATE OF DEATH

Reg. Dist. No. 03244

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7504 Piney Branch Rd.		d. STREET ADDRESS 7504 Piney Branch Rd.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle Last ELKAN		4. DATE OF DEATH Month March Day 15 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1895
9. AGE (In years lost birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM ELKAN		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Gerald Elkan - 7504 Piney Branch Rd., SS., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, chronic (lymphatic) 204-0 DUE TO (b) 4.5 months Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 63 to March 15 , 19 61 , that I last saw the deceased alive on March 13 , 19 61 , and that death occurred at 5:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Alvin W. Eger, M.D. 1801 Eye Street, N. W. March 15, 1961			
ACTUAL SIGNATURE Alvin W. Eger		PHYSICIAN'S NAME (Type) ALVIN W. EGER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-61	
22c. NAME OF CEMETERY OR CREMATORY National Capital Hebrew Cemetery		22d. LOCATION (City, town, or county) (State) Washington, DC	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., NW		24a. REC'D BY REGISTRAR DATE MAR 17 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT - DIVISION OF INVESTIGATION

3256

100-3256

Monogamy

Silver Spring

7504 Piney Branch Rd.

GEORGIA

Male White

Married

ABRAHAM ELKAN

No

Silver Spring

7504 Piney Branch Rd.

ILLINOIS

April 8, 1905

Germany

Unknown

61

March 15

62

USA

Gerald Elkan - 7504 Piney Branch Rd.

Partial 3-10-61 National Capital Hebrew Cemetery Washington, DC

Hebrew Burial Society - 3001 14th St., NW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO VITAL RECORDS: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3257

CERTIFICATE OF DEATH

Item 9 Film G282 3/9/61 mh

03245

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 Rockville d. STREET ADDRESS 518 Beall Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy First Middle Last 4. DATE OF DEATH March 4 19 61 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 3/3/05 9. AGE (In years last birthday) 56 5/11 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary 13. FATHER'S NAME Harry St. George Stearns		10b. KIND OF BUSINESS OR INDUSTRY Library, N.I.H. 11. BIRTHPLACE (County & State, or foreign country) California 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 556-010343 17. INFORMANT Address Mrs. Elizabeth Tallon Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Metastatic ca. to lung DUE TO (c) Carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 6 mos 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/3/1961 to 3/4/1961 , that (I) (we) last saw the deceased alive on 3/4/1961 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones M.D.		22b. DATE SIGNED 3/4/61	
22c. PHYSICIAN'S NAME (Type) Stephen N. Jones		22d. ADDRESS Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3-6-61	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City, town or county) (State) SUITLAND MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BL Langansky		25a. REC'D BY REGISTRAR AW 25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

2257

47

Montgomery

Bowman

Suburban Hospital

Dorothy

George

Secretary

Henry St. George

No

Library, N.I.R.

Stearns

California

Old Road

Mrs. Elizabeth Taylor

Rockville, Md.

U.S.A.

Ward

St

228 Pearl Ave.

Rockville

Maryland

Montgomery

Reginald N. Jones

Rockville, Md.

CEPHAR HILL, CALIF. 9-1-51

MAY 21 1951

3258

CERTIFICATE OF DEATH

Reg. Dist. No. 03246

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium		d. STREET ADDRESS 1112 16TH ST. NW	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle LAURIE Last EVANS		4. DATE OF DEATH Month March Day 5, Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1884
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	11. IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) LOUISIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES R. TANNER		14. MOTHER'S MAIDEN NAME ANNIE LOUISE ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
INFORMANT Sanitarium Records...		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 2 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture R. Hip - fall Jan 1961		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Jan 1961 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Resmor San.		20f. (City or town) (County) (State) Washington D.C.	
21. I certify that I attended the deceased from 1955 , 19, to 3-5 , 19 61 , that I last saw the deceased alive on 3-5 , 19 61 , and that death occurred at 3:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Geo. R. Huffman M.D.		ADDRESS (Street, city or town, state) 1912 R. St. NW, D.C.	
DATE SIGNED 3/5/61			
PHYSICIAN'S NAME (Type) George R. Huffman, 1912 R. Street, NW., Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-8-1961	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Sons		24a. REC'D BY REGISTRAR MAR 8 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

3258

DEATH

Division of Columbia

Washington

Washington

Washington

Research Laboratory

1944

1944

1944

1944

Female

1944

Washington

Washington

1944

Washington

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3259

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03247

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> h. STREET ADDRESS <u>8515 Flower Ave</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> <u>IDA</u> <u>Everdale</u>		4. DATE OF DEATH <u>MARCH</u> <u>5</u> , 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-80</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
13. FATHER'S NAME <u>theodore Schreum</u>		14. MOTHER'S MAIDEN NAME <u>Primer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Ethel - Washington Sanatorium & Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>terminal pneumonia</u> DUE TO (b) <u>arteriosclerotic heart disease & congestive failure</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>4 days</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year <u>3/4</u> Hour a.m. <u> </u> p.m. <u> </u>	22b. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	22d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> , 19 <u>61</u> , to <u>3/5</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>61</u> , and that death occurred at <u>4:40</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>HUGH IREY</u>		22b. DATE SIGNED <u>3/5</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGH IREY</u>		22d. ADDRESS <u>7105 RIGGS Rd. Landover, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 8 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>	23d. LOCATION (City, town, county) (State) <u>Prince George's Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. ...</u>		25a. REC'D BY REGISTRAR <u>MAR 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. ...</u>		25c. ADDRESS <u>254 CARROLL ST NW D.C.</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3260
CERTIFICATE OF DEATH

03248

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 hr. 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 4927 Jamestown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Victor Oris FEIK		4. DATE OF DEATH March 18 19 61		5. SEX Male	
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-98	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restauranteur		10b. KIND OF BUSINESS OR INDUSTRY Retired		9. AGE (In years last birthday) 63 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME George Christian FEIK		14. MOTHER'S MAIDEN NAME Elizabeth LAUER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give number or last of service)		17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease DUE TO (c)	

INTERVAL BETWEEN ONSET AND DEATH
3 hours
10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from March 17, 1961, to March 18, 1961, that (I) (the physician) saw the deceased alive on March 18, 1961, and that death occurred at 12:21 AM, from the causes and on the date stated above.		22a. SIGNATURE Vernon N. Houk	
22b. DATE 3-18-61		22c. PHYSICIAN'S NAME (Type) Vernon N. HOUK, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 3-19-61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Park		23d. LOCATION (City, town or county) Sharon, Mercer Co., Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAR 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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U. S. Naval Hospital, Baltimore, Md.

(Initials)

1. Mr. J. M. Smith

2. Mr. J. M. Smith

U. S. Naval Hospital, Baltimore, Md.

3. Mr. J. M. Smith

4. Mr. J. M. Smith

U. S. Naval Hospital, Baltimore, Md.

5. Mr. J. M. Smith

U. S. Naval Hospital, Baltimore, Md.

6. Mr. J. M. Smith

7. Mr. J. M. Smith

8. Mr. J. M. Smith

9. Mr. J. M. Smith

10. Mr. J. M. Smith

11. Mr. J. M. Smith

12. Mr. J. M. Smith

13. Mr. J. M. Smith

14. Mr. J. M. Smith



1333

CERTIFICATE OF DEATH

0322

1
John R. Fisher
Grand and Empire
M. W. 3-20-72 27
Benton Florie
Washington State Hospital
Mary D. Fisher
P.O.
N.C.D.

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03250

Carlina S. Kraus

VR A15 (4)
15M 9/60

1993

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3263

03251

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 34 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM THOMAS FLYNN				4. DATE OF DEATH Month Day Year MARCH 23, 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 27, 1885	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer				10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME THOMAS FLYNN				14. MOTHER'S MAIDEN NAME EMMA CRAWFORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 10/10/1944 to 3/23/1961 , that (I) (we) last saw the deceased alive on 3/21/1961 , and that death occurred at 9:20p , from the causes and on the date stated above.							
22a. SIGNATURE James P. Kerr M.D.				22b. DATE SIGNED 3/25/61			
22c. PHYSICIAN'S NAME (Type) J. P. KERR, M. D.,				22d. ADDRESS DAMASCUS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/61		23c. NAME OF CEMETERY OR CREMATORY Howard Chapel		23d. LOCATION (City, town, or county) (State) Long Corner, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molemanth				25a. REC'D BY REGISTRAR Damascus, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
25c. DATE MAR 28 '61							

3553

(M)

1930

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Date of Death	
John Doe		Jan 1, 1900		Jan 1, 1950	
Place of Birth		Place of Death		Cause of Death	
New York City		New York City		Heart Disease	
Occupation		Married		Buried	
Teacher		Yes		Yes	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
Jan 1, 1950		New York City		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3264

CERTIFICATE OF DEATH

03252

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10 LAUER TERRACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STANLEY Middle BARBOUR Last FOLTZ		4. DATE OF DEATH Month MARCH Day 9 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1894
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (retired) Wash. Post Newspaper		10b. KIND OF BUSINESS OR INDUSTRY Wash. Post Newspaper	
11. BIRTHPLACE (State or foreign country) ALEXANDRIA, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE J. FOLTZ		14. MOTHER'S MAIDEN NAME MARY N. BARBOUR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-03-2876	
17. INFORMANT MRS. FRANCES E. FOLTZ, 10 Lauer Terrace Silver Spring, Md.		Address 10 Lauer Terrace Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (o) Uremia (Acute Renal Failure) 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic Cirrhosis of Liver (b) Diabetes Mellitus (c) Undetermined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Undetermined			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jun 1, 1950 to Mar 9, 1961 , that (I) (we) last saw the deceased alive on Mar 9, 1961 and that death occurred 6 PM from the causes and on the date stated above.			
22a. SIGNATURE George L Ball		22b. DATE SIGNED Mar 9, 1961	
22c. PHYSICIAN'S NAME (Type) George L Ball		22d. ADDRESS 10620 Georgia Ave Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/11/61	
23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pomeroy, Inc.		25a. REC'D BY REGISTRAR DATE MAR 14 '61	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL RECORDS: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3265

03253

M

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional residence, give admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 9 days		d. STREET ADDRESS 3831 Rodman Street, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle B Last Fox		4. DATE OF DEATH 3/27/61 Month 3 Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/96 Last 64 yrs. Months 6 Days 11 Hours 19 Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Beatrice Ice Cream Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Enoch Fox		14. MOTHER'S MAIDEN NAME Hopkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-07-3141	
17. INFORMANT Hilda A. Fox, wife		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myo CARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/17 to 3/27 , 19 61 , that (I) (was) last saw the deceased alive on 3/26 , 19 61 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE DeWitt E. DeLawter		22b. DATE SIGNED 3/27/61	
22c. PHYSICIAN'S NAME (Type) DEWITT E. DELAWTER, M.D.		22d. ADDRESS 8025 ABERDEEN RD Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE S.H. Harris		25a. REC'D BY REGISTRAR 2901-14th St. N.W. D.C.	
25b. REGISTRAR'S SIGNATURE DATE MAR 28 '61		25c. REGISTRAR'S SIGNATURE Arthur S. Harris	

(M)

(I)

0325

0325

Superman Hospital

64

Marvin

Hovins

Knock Fox

577-07-3121

Walter A. Fox, wife

Walter A. Fox

24/10/60 2801-14-21 Mr. D.C. W. 2801

2801-14-21

2801-14-21

2801-14-21

2801-14-21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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BP 1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
3266 CERTIFICATE OF DEATH 03254										
1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 13 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton 32					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital					d. STREET ADDRESS 14000 Layhill Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles		First Charles		Middle Lee		Last Frazier		4. DATE OF DEATH Month March Day 5 Year 1961		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1961		9. AGE (In years lost birthday) yrs. 12 57		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eddie Bain Frazier, Jr.					14. MOTHER'S MAIDEN NAME Shirley Ann Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital records Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Immaturity DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/4 1961 to 3/5 1961 , that (I) (we) last saw the deceased alive on 3/5 1961 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Richard A. Yates M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/5/61	
22c. PHYSICIAN'S NAME (Type) Dr. Richard A. Yates, M.D.					22d. ADDRESS Olney, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/61		23c. NAME OF CEMETERY OR CREMATORY County Burial Ground			23d. LOCATION (City, town, or county) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey					ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 10 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Huns	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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15M 9/59

3267

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03255

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>4 days.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>5416 BURLING ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET (NMN) GALLAGHER</u> 4. DATE OF DEATH Month Day Year <u>MARCH 9 1961</u>															
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 22, 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>				11. BIRTHPLACE (State or foreign country) <u>Juniata Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JOHN DINSMORE</u>						14. MOTHER'S MAIDEN NAME <u>WATT</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. H. R. GALLAGHER</u> Address <u>5416 Burling Rd. Bethesda, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>generalized arteriosclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.												INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u> <u>4 yrs.</u> <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1957</u> to <u>March 9</u> 1961 , that (I) (we) last saw the deceased alive on <u>March 4</u> 1961 , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Thomas E. Curtin</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/9/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Thomas E. Curtin</u>						22d. ADDRESS <u>4600 Connecticut Ave. N.W. Wash DC</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>3/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>				23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3268

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03256

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 82 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg d. STREET ADDRESS R.F.D. # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oswald Middle Buchanan Last Garver		4. DATE OF DEATH Month March Day 7 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1911
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Garver		14. MOTHER'S MAIDEN NAME Mary L. Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-09-4327	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-abdominal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured aortic aneurysm DUE TO (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Histoplasmosis, disseminated INTERVAL BETWEEN ONSET AND DEATH Hours Hours Months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 15, 1960 to March 7, 1961 , that (I) (we) last saw the deceased alive on March 7, 1961 , and that death occurred on March 7, 1961 from the causes and on the date stated above.			
22a. SIGNATURE Robert R. Carpenter, MD M.D.		22b. DATE SIGNED 3/7/61	
22c. PHYSICIAN'S NAME (Type) Robert R. Carpenter, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 10, 1961	
23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City, town, or county) (State) Carroll County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR MAR 9 '61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

0268

County

City

State

Interment

Funeral

Age

Sex

The Medical Center, Bethesda, Md.

Funeral

Funeral

Funeral

Funeral

January 2, 1911

Male

Funeral

Funeral

Funeral

May 1, 1911

George A. Carter

The National Board

210-1-107 The National Board, Bethesda, Md.

Hours

Interment

Hours

Interment

Hours

Interment

2

Histology, etc.

December 12, 1911

March 7

The Medical Center, Bethesda, Md.

of Health, Bethesda, Md.

George A. Carter

3269

CERTIFICATE OF DEATH

Reg. Dist. No.

03257

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b Since Oct. 1960			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 95 E. Wayne Ave., Apt. 412				d. STREET ADDRESS 95 E. Wayne Ave., Apt. 412			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CAROLYN Middle L. Last GASKINS		4. DATE OF DEATH Month MARCH Day 23 Year 1961					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1885	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED DILOTT				14. MOTHER'S MAIDEN NAME MARIE LOUISE (UNKNOWN)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT Mrs. James R. Fryrear, 9702 Dilston Road, Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic adenocarcinoma of lungs from breast INTERVAL BETWEEN ONSET AND DEATH 5-6 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 1946 to 23 March, 1961 that I last saw the deceased alive on 23 March, 1961 , and that death occurred at 10:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9006 Calverville Rd, Silver Spring, Md. DATE SIGNED 3/23/61							
ACTUAL SIGNATURE William D. Aud M.D.				PHYSICIAN'S NAME (Type) WILLIAM D. AUD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/27/61		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 28 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2288

(M)

(1)

DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
BIRTH DATE
BIRTH PLACE
MARRIAGE DATE
MARRIAGE PLACE
EDUCATION
OCCUPATION
RELIGION
SIGNED
WITNESSED
REGISTERED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3270

CERTIFICATE OF DEATH

03258

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Montgomery**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Olney** c. LENGTH OF STAY IN 1b **64 Days**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Montgomery General Hospital** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First **Rose** Middle **Morris** Last **Gilpin** 4. DATE OF DEATH Month **March** Day **25** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH **May 10, 1869** 9. AGE (In years last birthday) **91** yrs. IF UNDER 1 YEAR: Months **0** Days **0** Hours **0** Min. **0** IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Frederick Stabler** 14. MOTHER'S MAIDEN NAME **Martha Brooke**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **None** 17. INFORMANT Address **Hospital Records; Olney, Maryland**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Uremia**
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) **Chronic cardiovascular-renal disease**
DUE TO (c) **Generalized arteriosclerosis**
INTERVAL BETWEEN ONSET AND DEATH **4 days**
5 yrs
10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Fractured femur 2 months ago** 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Fell at home**

20c. TIME OF INJURY Month, Day, Year Hour a. m. **Jan 30 1961** p. m. **While at work** ☐ Not while at work ☐ 20d. INJURY OCCURRED **Home** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home** 20f. (City or town) **Olney** (County) **Montg.** (State) **md.**

21. I certify that (I) (this hospital) attended the deceased from **Jan 30 1961** to **March 25 1961**, that (I) (we) last saw the deceased alive on **March 24 1961**, and that death occurred at **1:02 PM**, from the causes and on the date stated above.

22a. SIGNATURE **A.D. Bonifant** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED **March 29 1961**

22c. PHYSICIAN'S NAME (Type) **A.D. Bonifant, M.D.** 22d. ADDRESS **Sandy Spring, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **3/27/61** 23c. NAME OF CEMETERY OR CREMATORY **Friends Meeting House** 23d. LOCATION (City, town, or county) (State) **Sandy Spring, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **Tyson Wheeler** ADDRESS **1331 E. Montg. Ave. Rockville, Md.** 25a. REC'D BY REGISTRAR **March 29 '61** 25b. REGISTRAR'S SIGNATURE **Charles L. Evans**

3270

CERTIFICATE OF DEATH

1937

Monterey

San Jose

Monterey

Quincy

at Large

Quincy

Monterey County General Hospital

Home

Monterey

Monterey

March 21

at

Female

White

May 10, 1937

Monterey

UTB

Frederick Stadler

Martha Brooke

Monterey County General Hospital

A. D. Bonavent, M.D.

San Jose, Cal.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3271

03259

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 12 hrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Wheaton		d. STREET ADDRESS 3501 Henderson Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Doris A. Glover				DATE OF DEATH March 31 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dry Goods Store		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Yates				14. MOTHER'S MAIDEN NAME Mary Ann Rebidas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-30-4937		17. INFORMANT Stanley B Glover (Husband) Damascus Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 648.3 DUE TO Generalized Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Perforation of Stems DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pregnancy - 1st Trimester				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Francis J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-61		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Francis X. Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR MAR 23 '61		24b. REGISTRAR'S SIGNATURE Arthur E. Huns	

MEDICAL CERTIFICATION

1752

• *Idem notum*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3272

CERTIFICATE OF DEATH

Reg. Dist. No.

03260

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - ROCKVILLE</u>		c. LENGTH OF STAY IN 1b <u>6 Mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4502 WOODLARK PLACE</u>		d. STREET ADDRESS <u>4502 WOODLARK PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>-</u> Last <u>GOLDBERG</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11, 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>AARON GOLDBERG</u>		14. MOTHER'S MAIDEN NAME <u>DEBORAH TEPPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>077-28-4107 (Chm)</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1958</u> to <u>March 13, 1961</u> that I last saw the deceased alive on <u>March 13, 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave 3/13/61</u>	
PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY, M.D.</u>		DATE SIGNED <u>3/13/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-15-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ORADELL, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY & SONS - 3501-14th St NW</u>		24a. REC'D BY REGISTRAR <u>MAR 15 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3273 CERTIFICATE OF DEATH 03261

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 2505 Cherokee Avenue	
3. NAME OF DECEASED (Type or print) John Lynn Goshorn, Jr.		4. DATE OF DEATH March 2, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1915
9. AGE (In years lost birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Office	
11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Goshorn		14. MOTHER'S MAIDEN NAME Jennie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT The Medical Record,		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Bronchogenic Carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 5 Minutes 6 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 20, 1961 to March 2, 1961 , that (I) (we) last saw the deceased alive on March 2, 1961 , and that death occurred at 8:40 AM from the causes and on the date stated above.			
22a. SIGNATURE Vincent H. Bono Jr. M.D.		22b. DATE SIGNED 3/2/61	
22c. PHYSICIAN'S NAME (Type) Vincent H. Bono M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-61	
23c. NAME OF CEMETERY OR CREMATORY Springhill		23d. LOCATION (City, town, or county) (State) Charleston W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE Paul Funeral Home ADDRESS 4812 H Avenue NW Wash. DC.		25a. REC'D BY REGISTRAR MAR 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. K...			

CERIFICATE OF DEATH

3273

West Virginia

Shelton

10 days

2500 Riverside Avenue

The Clinical Center

Joshua, Jr.

John

John

March 10, 1975

John

John

John

John

John

John I. Goshorn

Yes

Yes

Not available

The Clinical Center, Bethesda, Maryland

John I. Goshorn

The Clinical Center

February 2, 1975

John I. Goshorn

The Clinical Center

Institute of Health

John I. Goshorn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3274

113263

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DC b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 37-days				d. STREET ADDRESS 417 Van Buren Street, N.W.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL HALL 10231 Candor Place				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OLIVE Y. GRAHAM		First Middle Last		4. DATE OF DEATH MARCH 15 1961		Month Day Year	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-15-1875	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John EDMONDSON			
14. MOTHER'S MAIDEN NAME NANCY RICKMAN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. yes ?				17. INFORMANT Records at Carroll Hall Sanitarium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, generalized, primary site undetermined. 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 199.2 DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 7 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 9, 1961 to March 15, 1961 , that (I) (we) last saw the deceased alive on March 9, 1961 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Blaine H. Eig				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 15, 1961	
22c. PHYSICIAN'S NAME (Type) BLAINE H. EIG				22d. ADDRESS 464 Cleveland Boulevard, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				ADDRESS Wash. DC		25a. REC'D BY REGISTRAR MAR 16 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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Washington

17 Jan 1961

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W. J. R. R.

Records at Control

John

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W. J. R. R.

George

W. J. R. R.

Edgar Hill

2/18/61

The S. S. Hill Co. - 2991 1st St. S. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3275

CERTIFICATE OF DEATH

03263

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b 21 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6822 Delaware Street		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 6822 Delaware Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WARREN WHYTE GRIMES		4. DATE OF DEATH Month March Day 5 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1890
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin Pierce Grimes		14. MOTHER'S MAIDEN NAME Mary Hunter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Helen Grimes--Chevy Chase, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/5/58 , 19 58 , to 3/5 , 19 61 , that (I) (we) last saw the deceased alive on 3/3 , 19 61 , and that death occurred at 11:40 AM , from the causes and on the date stated above.			
22a. SIGNATURE John A. Reisinger M.D.		22b. DATE SIGNED 3/5/61	
22c. PHYSICIAN'S NAME (Type) JOHN A. REISINGER		22d. ADDRESS 901-20th N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/8/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.		25a. REC'D BY REGISTRAR MAR 7 '61	
ADDRESS 2901 14th St., N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Arthur L. Knudsen	

VR A15 (4)
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North Carolina

Virginia

North Carolina

Gray Co. 22

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Gray Co. 22

6822 Delaware Street

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August 2, 1890 to

August 2, 1890 to

U.S.A.

Alexander, Va.

U.S.A.

Gray Co. 22

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6822 Delaware Street

6822 Delaware Street

no

Gray Co. 22

Gray Co. 22

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3276 CERTIFICATE OF DEATH

03264

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Sanitarium				d. STREET ADDRESS 1622 Fitzgerald Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lucy First Middle Last Gutridge				4. DATE OF DEATH Month MARCH Day 23 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-1878		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carter Williams				14. MOTHER'S MAIDEN NAME Emily F. Leavitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Mrs. Virginia G. Mayers (Daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cerebral vascular accident (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 12 hours 9 months years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 8 1960 to March 23 1961 that (I) (we) last saw the deceased alive on March 23 1961 , and that death occurred on March 23 1961 at 9:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE G. Bowditch Hunter, Jr. M.D.				22b. DATE SIGNED March 23 1961		22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr., M.D.	
22d. ADDRESS 801 Veins Mill Road Rockville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3-27-1961		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Gaudin, Inc. 1756 Pa. Ave. N.W.				25a. REC'D BY REGISTRAR MAR 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hunter	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3277 CERTIFICATE OF DEATH 03265											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7900 Glendale Rd.						d. STREET ADDRESS 7900 Glendale Rd.					
3. NAME OF DECEASED (Type or print) James Edward Halley						4. DATE OF DEATH Month March Day 17 Year 19 61					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/27/78		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President of Washington Planograph Co.						10b. KIND OF BUSINESS OR INDUSTRY Virginia			11. BIRTHPLACE (County & State, or foreign country) U.S.A.		
13. FATHER'S NAME Edward S. Halley						14. MOTHER'S MAIDEN NAME Mary Blair					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no						16. SOCIAL SECURITY NO. 578-07-7678					
17. INFORMANT Paul F. Loehler						Address same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO (c) Heart PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart										INTERVAL BETWEEN ONSET AND DEATH 3 hrs 15 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Prince Georges County, Md.		20g. (County) Prince Georges County, Md.		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 2/1/1956 to 3/1/1961 , that (I) (we) last saw the deceased alive on 3/1/1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE John E. Everett M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/1/61			
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT						22d. ADDRESS 9400 Conn. Av. KENSINGTON					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/20/1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.						ADDRESS -2901 14th St., N.W.		25a. REC'D BY REGISTRAR MAR 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	
The S.H. Hines Co.						Washington 9, D.C.					

(M)

(I)

The J. H. Hines Co. - 2501 1st St. N.W.
Washington 25, D.C.
2501 1st St. N.W.
Washington 25, D.C.
J. H. Hines Co. - 2501 1st St. N.W.
Washington 25, D.C.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03266									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					c. LENGTH OF STAY IN life <u>life</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>218 N. Washington St.</u>					d. STREET ADDRESS <u>218 N. Washington St.</u>				
3. NAME OF DECEASED (Type or print) <u>Charles Elias Hammond</u>					4. DATE OF DEATH Month <u>Mar.</u> Day <u>18</u> Year <u>1961</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/25/1961</u> 94		9. AGE (In years last birthday) <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Wm. Hammond</u>					14. MOTHER'S MAIDEN NAME <u>Maggie Giddings</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT <u>Geo. W. Johnson</u>					Address <u>222 N. Washington St. Rockville, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF <u>3/27/61</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u>					22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>				
23. FUNERAL DIRECTOR <u>Robert L. Suroden</u>					24e. REC'D BY REGISTRAR DATE <u>MAR 30 '61</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					DATE				

DATE SIGNED

Mar. 20, 1961

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MAINTENANCE DEPARTMENT OF HEALTH
FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
JAN 10 1964
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including names, dates, and references. Some words like "Bureau", "New York", and "subject" are faintly visible.]



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3279

CERTIFICATE OF DEATH

Item 23b, Film G284 4/6/61 iwk

03267

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bethesda Sanitarium				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 4740 Bradley, Boulevard d. STREET ADDRESS 1 Chevy Chase e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Washington Last Harris				4. DATE OF DEATH Month March Day 29 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5 - 1871	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 11 Days 24		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John Harris				14. MOTHER'S MAIDEN NAME Maria Fish			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT George J. Harris-son-		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCD DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 years 25 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from 3 June 1961 to 29 March 1961 , that (2) we lost saw the deceased alive on 29 March 1961 , and that death occurred at 7:20 M. from the causes and on the date stated above.							
22a. SIGNATURE Robert Young				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/29/61	
22c. PHYSICIAN'S NAME (Type) Robert Young				22d. ADDRESS 2500 Calvert St., N.W. Washington 8, D. C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 3 '61 DATE	
				25b. REGISTRAR'S SIGNATURE Arthur L. Frame			

2002-03-18

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3280 CERTIFICATE OF DEATH

03268

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 63 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ora Middle Vance Last Hartbarger				4. DATE OF DEATH Month March Day 30 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19, 1923	
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Hartbarger				14. MOTHER'S MAIDEN NAME Cleopatria Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Records				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia DUE TO chronic hereditary nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic hereditary nephritis (c) chronic hereditary nephritis INTERVAL BETWEEN ONSET AND DEATH 5 years 17 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from January 26, 19 61 to March 30, 19 61 that (I) (we) last saw the deceased alive on March 30, 19 61 , and that death occurred at 4:55 PM from the causes and on the date stated above.							
22a. SIGNATURE Norman H. Bell				22b. DATE SIGNED 3-30-61			
22c. PHYSICIAN'S NAME (Type) Norman H. Bell M.D.				22d. ADDRESS National Institutes of Health The Clinical Center, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/1/1961		23c. NAME OF CEMETERY OR CREMATORY Hartbarger Cemetery		23d. LOCATION (City, town, or county) (State) Lexington, Va. (R.F.D.#1)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR APR 3 1961			
25b. REGISTRAR'S SIGNATURE Arthur L. Hines							

3580

CERTIFICATE OF DEATH

0830

DATE OF DEATH

DATE OF BIRTH

AGE

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PLACE OF BIRTH

PLACE OF DEATH

CAUSE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3281

CERTIFICATE OF DEATH

Reg. Dist. No. 03269

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 12 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 HILLMOOR DRIVE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 215 HILLMOOR DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRIE Middle GAY Last HASKIN		4. DATE OF DEATH Month MARCH Day 9 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/88
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman (retired)		10b. KIND OF BUSINESS OR INDUSTRY Emerson & Orme Buick	
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES W. HASKIN		14. MOTHER'S MAIDEN NAME MARIA EMPEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW# 1		16. SOCIAL SECURITY NO. 577-18-7609	
17. INFORMANT Mrs. Nellie R. Haskin, 215 Hillmoor Dr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary artery thrombosis & myocardial infarction + resultant congestive failure 12 hrs. DUE TO (b) Generalized arteriosclerotic cardiac disease DUE TO (c) Generalized arteriosclerotic cardiac disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , 19 to 9 March , 19 61 , that I last saw the deceased alive on 9 March , 19 61 , and that death occurred at 6: A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9301 Colesville Road Silver Spring, Maryland DATE SIGNED 3/9/61 ACTUAL SIGNATURE Ernest E. Harmon M.D. PHYSICIAN'S NAME (Type) ERNEST E. HARMON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/13/61	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Pumphrey, Inc. Raymond A. Jaska		24a. REC'D BY REGISTRAR MAR 15 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3282

CERTIFICATE OF DEATH

Reg. Dist. No. 03270

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON 37			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11703 JUDSON ROAD				d. STREET ADDRESS 11703 JUDSON ROAD 1			
3. NAME OF DECEASED (Type or print) First HOWARD Middle HAUG Last HAUG				4. DATE OF DEATH Month MARCH Day 27 Year 1961 19			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6, 1909		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. GOVERNMENT EMPLOYEE			10b. KIND OF BUSINESS OR INDUSTRY NEW YORK		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FREDERICK DAVID HAUG			14. MOTHER'S MAIDEN NAME FREDA —				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. RONALD RICH		Address 816 UNIVERSITY BLVD., E. S.S., MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary oc Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO (c) atherosclerosis, coronary							INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/15/ 19 61 , to 3/27/ 19 61 , that I last saw the deceased alive on 3/26/ 19 61 , and that death occurred at 6:45 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald Nelson			ADDRESS (Street, city or town, state) 10620 Georgia Ave., S.S., Md.			DATE SIGNED 3/27/61	
PHYSICIAN'S NAME (Type) DR. DONALD NELSON			10620 GEORGIA AVE., S.S., MD.				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-29-61	22c. NAME OF CEMETERY OR CREMATORIUM KING DAVID MEMORIAL GARDEN		22d. LOCATION (City, town, or county) (State) FALLS CHURCH, VIRGINIA		
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS-3501 14th Street, NW			24a. REC'D BY REGISTRAR DATE APR 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1988

DECEASED

DATE OF DEATH

1105 JUDSON ROAD

1105 JUDSON ROAD

WILSON, JAMES M.

WILSON

WILSON

MI 51

JUNE 6, 1988

WILSON

MI 51

USA

NEW YORK

U.S. GOVERNMENT PRINTING OFFICE

WILSON

WILSON

WILSON, JAMES M. 1105 JUDSON ROAD, MI 51

MI 51

10000 BENTLEY AVE., MI 51

WILSON, JAMES M.

WILSON, JAMES M. 1105 JUDSON ROAD, MI 51

WILSON, JAMES M.

WILSON, JAMES M. 1105 JUDSON ROAD, MI 51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3283
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Montgomery County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>WEST VIRGINIA</i> b. COUNTY <i>85X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GERMANTOWN MD.</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MARILANDER REST HOME</i>		d. STREET ADDRESS <i>PARKERSBURG</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>EMMA DUDLEY HEATON</i>		4. DATE OF DEATH Month Day Year <i>MARCH 3 1961</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 24 1887</i>
9. AGE (In years and birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>h.w.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTH PLACE (State or foreign country) <i>PARKERSBURG, W. VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN W. DUDLEY</i>		14. MOTHER'S MAIDEN NAME <i>EMMA G. LEONARD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT Address <i>GENERAL LEONARD J. HEATON WRAMC AC.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/15 1961</i> to <i>3/3 1961</i> , that (I) (we) last saw the deceased alive on <i>3/3 1961</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>James P. Kerr</i>		22b. DATE SIGNED <i>3/3/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>James P. Kerr</i>		22d. ADDRESS <i>Damascus, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>MAR. 6, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>MOUNT OLIVET</i>		23d. LOCATION (City, town, or county) (State) <i>PARKERSBURG W. VA.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>RINALDI FUNERAL HOME 816 N. N.E. RD</i>		25a. RECEIVED BY REGISTRAR DATE <i>MAR 7 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3284 CERTIFICATE OF DEATH 03272											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY in 1b <u>23 days</u>						d. STREET ADDRESS <u>426 Pershing Drive</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>						• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>Fowler</u> Last <u>Heiss</u>						4. DATE OF DEATH Month <u>3</u> - Day <u>9</u> - Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-85</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HLW.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Robert Birkhead</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Fowler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <u>NO.</u>						16. SOCIAL SECURITY NO. <u>UNKNOWN.</u>					
17. INFORMANT <u>Hospital Records</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Postmenary Embolism</u> DUE TO (b) <u>Adenocarcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral Vascular brain accident.</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I, certify that (I) (this hospital) attended the deceased from <u>Feb 15, 1961</u> to <u>3/9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/9</u> , 19 <u>61</u> , and that death occurred at <u>7:35</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Raymond O. West</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>						22d. ADDRESS <u>7600 Carrol Ave, Takoma Park, Maryland.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3.13.61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT WINSTON CEM.</u>		23d. LOCATION (City, town or county) <u>WASH. D.C. 3201 BLADENSBURG, N.E.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birkhead</u>						ADDRESS <u>3034 Mt. View</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1234

1234



1000 Control (no, extra look, hand)

1000 Control (no, extra look, hand)

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03273

3285

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 70 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Erie c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75X-3 d. STREET ADDRESS 926 West 16th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard John Hellman, Jr.				4. DATE OF DEATH Month Day Year March 20 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1958	
9. AGE (In years last birthday) 2		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Richard John Hellman, Sr.				14. MOTHER'S MAIDEN NAME Patricia Shearer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO 199X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Ca, Embrolal Cell DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 wks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 9 1961 to March 20 1961 , that (I) (we) last saw the deceased alive on March 20 1961 and that death occurred at 3:45 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Michael Z. Lazor				22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22c. PHYSICIAN'S NAME (Type) MICHAEL Z. LAZOR, M.D.	
22d. SIGNATURE Michael Z. Lazor		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22f. SIGNATURE Michael Z. Lazor		22g. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 3-21-61		23b. DATE THEREOF 3-21-61		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) Erie, County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR MAR 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. House				25c. REGISTRAR'S SIGNATURE Arthur L. House			

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050

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M

CERTIFICATE OF DEATH

1923

M

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
Theodore J. ...		Male		35		May 20, 1888		New York, N.Y.		New York, N.Y.		Heart Disease		May 20, 1923		New York, N.Y.		5:00 P.M.		J.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3286

CERTIFICATE OF DEATH

03274

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 mo 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1508 - 18th St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert John Hook</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/82</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham L. Hook</u>		14. MOTHER'S MAIDEN NAME <u>Annie Fritz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 153.3 DUE TO (b) <u>Post operative inactivity</u> DUE TO (c) <u>Surgery for Ca. Recto sigmoid</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>-</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Feb. 27, 1961</u> , to <u>March 28, 1961</u> , that (1) <u>no</u> last saw the deceased alive on <u>March 28, 1961</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Welfred W. Eastman</u> M.D.	
22b. DATE <u>March 28, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Welfred W. Eastman</u>	
22d. ADDRESS <u>-</u>		22e. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		22g. DATE <u>APR 7 '61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/31/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. LINCOLN</u>		23d. LOCATION (City, town or county) (State) <u>B/ADENSBURG MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Handon Funeral Home - 3831 - So. G. St. N.W.</u>		25. ADDRESS <u>-</u>	

(M)

388

03274

Washington Southern - Station 1208 - W. B. E.
Robert Jones
9/30/82
Abraham W. Horn
Hospital Records
Post operative activity
Palmonary Embolism

Chief of Medicine
C. Alfred St. El

61 11/10/88 61

Signature 8/1/81 F. J. Smith
Abraham W. Horn - 388 - 26-111 - 11/1/81

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3287

CERTIFICATE OF DEATH

03275

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		d. STREET ADDRESS 108 Primrose Street	
3. NAME OF DECEASED (Type or print) Mary Snow Horton		4. DATE OF DEATH March 10 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/30/75
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Schoolteacher	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Horton		14. MOTHER'S MAIDEN NAME Elizabeth Rich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Florence Seward (Sister)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, acute, severe DUE TO Conditions, if any which gave rise to immediate cause (b) Hemolytic Staphylococcus causing the underlying cause listed. (c) Source undetermined.		INTERVAL BETWEEN ONSET AND DEATH 8 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalised.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1250 to 3:10 , 1961, that (I) (we) last saw the deceased alive on 3:19 , 1961, and that death occurred at 5:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE Stewart Clapp		22b. DATE SIGNED 3-10-61	
22c. PHYSICIAN'S NAME (Type) Stewart Clapp		22d. ADDRESS 4740 Chevy Chase Dr. Chevy Chase Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/11/1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR MAR 13 '61	
ADDRESS 2901 14th St. N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

3222

Montgomery

Bellevue

Stanton

Mary

Female White

Married

George Horton

I

No

No

Bellevue Ohio

New Jersey

U.S.A.

Elizabeth Rich

Mrs. Florence Howard (State) Same as above

Horton

Shaw

3/20/15

85

March 10

61

108 Pittsford Street

Quevy Chase

7 days

Married

04230

Montgomery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3288
CERTIFICATE OF DEATH

03276

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1703 Tweed St., c/o Craig e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Coralee Theresa HULSEY		4. DATE OF DEATH Month March Day 1 Year 1961		5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-31-61		9. AGE (In years last birthday) yrs. 29		IF UNDER 1 YEAR Months 29		IF UNDER 24 HRS. Hours 29 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Virgil HULSEY						14. MOTHER'S MAIDEN NAME Barbara WALL											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Virgil Hulsey, same as #2 above Address											
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Hydrocephalus, congenital 752X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 29 days																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Feb. 19 1961 to March 1 1961		20g. (County) Washington		20h. (State) Tacoma							
21. I certify that (X) (this hospital) attended the deceased from Feb. 19 1961 to March 1 1961 , that (X) (we) last saw the deceased alive on March 1 1961 , and that death occurred at 1:15 AM , from the causes and on the date stated above.																	
22a. SIGNATURE <i>Gail A. Magid</i>				22b. DATE SIGNED 3-1-61				22c. PHYSICIAN'S NAME (Type) Gail A. MAGID, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				23b. DATE THEREOF 3-2-61				23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery				23d. LOCATION (City, town or county) (State) Tacoma Washington					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wheeler</i>				24a. ADDRESS Tyson Wheeler Funeral Home, Rockville, Md.				25a. REC'D BY REGISTRAR DATE MAR 3 '61				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>					

3338

(M)

(C)

(1)

NOTES

REMARKS (Cont.)

U. S. Naval Hospital

Company

Organization

Position

Activity

Rockville

1003 Tenth St., S.W.

PROPERTY

March 1

1-31-01

29

Germany

USA

Bureau Work

FIELD WORK

(%) Virgin Honey, some as above

Hydrocarbon, a. congenital

29 days

1003 Tenth St., S.W. March 1 1:15 PM

March 1 01

Field Notes

3-1-01

U. S. Naval Hospital, Bethesda, Md. Coll. A. M. Olin, Lt. MC, USN

Mountain View Cemetery

Section 3-1-01

Tyson Wheeler Funeral Home, Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3289

03277

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2501 Q St. NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Shillingford HUTCHINSON		4. DATE OF DEATH Month March Day 12 Year 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 February 1904 9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Philadelphia, Pa.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Hutchinson Jr.		14. MOTHER'S MAIDEN NAME Clara Shillingford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. WW11	
17. INFORMANT Catherine Hutchinson		Address 2501 Q St NW Washington D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple old areas of myocardial infarction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 6, 1961 to March 12, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 12, 1961 , and that death occurred at 10:20AM , from the causes and on the date stated above.			
22a. SIGNATURE Kenneth V. Harshman M.D.		22b. DATE SIGNED 3-13-61	
22c. PHYSICIAN'S NAME (Type) Kenneth V. HARSHMAN, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-15-61	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington, Va.
24. GENERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons		25a. REC'D BY REGISTRAR MAR 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

3233

11

January 1944

January 1944

(Name)

6 days

Washington

U.S. Naval Hospital

2501 0 301 11

Known

Washington

12

1

1944

Continued

19 January 1944

U.S. Navy

Washington, D.C.

Admiral Halsey

Office Washington

Yes

Continued Washington 2501 0 301 11

[Faint handwritten notes]

x

March 1944

March 1944

3-13-41

Kenneth W. HARRISON, Jr., U.S. Naval Hospital, Bethesda, Md.

April

3-13-41

Washington National

Washington, D.C.

Joseph G. Miller's 2 sons 1750 Penn. St. NW WDC

March 1941

March 1941

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03278

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rural</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Lee</u> Last <u>Jenkins</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-1884</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist - Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Don H. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Addie unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Melvin Lee Jenkins - R-2 Laurel Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	
22d. LOCATION (City, town, or country) <u>WASHINGTON, D.C.</u>				22e. (State)			
23. FUNERAL DIRECTOR <u>Raymond E. Ziska</u>				23b. ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>MAR 20 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>				DATE			

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3291

03279

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 7½ years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8403 16th St., Apt. 105			d. STREET ADDRESS 8403 16th St., Apt. 105		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RANDOLPH Middle LEE Last JENNINGS			4. DATE OF DEATH Month MARCH Day 22 Year 19 61		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 16, 1878		9. AGE (In years last birthday) 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR & BUILDER (RETIRED) OWN BUSINESS		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES T. JENNINGS			14. MOTHER'S MAIDEN NAME ELLA I. WRENN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Susie E. Jennings, 8403 16th St., Apt. 105 Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Found dead in bed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/22/61	
EXAMINER'S NAME (Type) FRANK J. BROSCART		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/24/61	22c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY		22d. LOCATION (City, town, or country) (State) GLENWOOD, MARYLAND	
23. FUNERAL DIRECTOR RAYMOND E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR MAR 27 '61	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

MEDICAL CERTIFICATION

101-1111
MAY 19 1964

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03521

MAILED 2-11-64
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-1111)
SUBJECT: [Illegible]
RE: [Illegible]
[The remainder of the document contains several paragraphs of text that are mostly illegible due to the quality of the scan. Some words like "New York", "Bureau", and "subject" are faintly visible.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3292
CERTIFICATE OF DEATH

03280

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Virginia b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 342A Eilers St. d. STREET ADDRESS 342A Eilers St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) David William JONES		4. DATE OF DEATH March 7 1961		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-53		9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) California				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Gayl R. JONES				14. MOTHER'S MAIDEN NAME Carolyn J. STRINGALL				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT (F) G. R. Jones, YN2, USN, Washington 25, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma, disseminated 200-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												INTERVAL BETWEEN ONSET AND DEATH 2 mos.							
21. I certify that (X) (this hospital) attended the deceased from March 1 1961 to March 7, 1961, that (X) (we) last saw the deceased alive on March 7, 1961, and that death occurred at 8:20PM, from the causes and on the date stated above.												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
22a. SIGNATURE H. A. PEARSON				22b. DATE 3-8-61				22c. PHYSICIAN'S NAME (Type) H. A. PEARSON, LCDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-10-61				23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery				23d. LOCATION (City, town or county) (State) Rockville Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				25a. REC'D BY REGISTRAR DATE MAR 10 '61				25b. REGISTRAR'S SIGNATURE Arthur S. House				25c. DATE MAR 10 '61							

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U. S. Naval Hospital

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(b) D. H. Jones, YMS, UMI, Washington SD, D. C.

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1. NAME : _____

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3293 CERTIFICATE OF DEATH 03281

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home</u>		d. STREET ADDRESS <u>10005 Renfrew Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> (NMI) Middle <u>Jordens</u> Last <u>Jordens</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1897</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining Camps</u>	
11. BIRTHPLACE (State or foreign country) <u>Cincinnati Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jordens</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Stahr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs Roma Pettingill, 10005 Renfrew Rd. Md.</u>		Address <u>Silver Sp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with metastases</u> DUE TO (b) <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiectasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 1958</u> , to <u>March 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 15, 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		22b. DATE SIGNED <u>March 24, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>	23b. DATE THEREOF <u>3/29/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>DENVER, COLORADO</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAR 28 '61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kuma</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3294				CERTIFICATE OF DEATH				03282			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Chevy Chase</u> d. STREET ADDRESS <u>17409 Ridgewood AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Dorothy Constance Kampe</u>		4. DATE OF DEATH <u>MARCH 25 1961</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WISCONSIN</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George J. Brandt</u>				14. MOTHER'S MAIDEN NAME <u>Genevieve M. Frost</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> DUE TO <u>Cancer of abd cavity, recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Cancer of colon removed in November (1961)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 4-5 months</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>2/9/61</u> to <u>3/25/61</u> , that (I) (we) last saw the deceased alive on <u>3/26/61</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles H. Holohan</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3/25/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>CH Holohan MD</u>				22d. ADDRESS <u>500 Underwood St. N. W. Wash. DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

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Robert A. Remondy, Baltimore, Maryland
Burial 3/28/01, Fort Lincoln Cemetery, Rockville, Maryland
303 Underwood St., N. W., Wash., D.C.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

3295

3295

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03283

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY in 1b <u>5 yrs</u>				d. STREET ADDRESS <u>22 Manchester Pl. apt 304</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>22 Manchester Place apt 304</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Kane</u>				4. DATE OF DEATH <u>Mar 28 1961</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 29 1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Estonia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Kane</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ruutel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>139-26-3537</u>		17. INFORMANT <u>Vali Ksenia</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brozant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Brozant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	
23. FUNERAL DIRECTOR <u>WARNER E. DUMPHREY, INC.</u>				24a. REGISTERED BY REGISTRAR <u>APR 3 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>SILVER SPRING, MD.</u>				24c. LOCATION (City, town, or country) <u>WASHINGTON, D.C.</u>		(State)	

MEDICAL CERTIFICATION

2

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3296
03284
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 58 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isidore Middle (None) Last Kassman		4. DATE OF DEATH Month March Day 2 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fur Merchant		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mordechai Kassman		14. MOTHER'S MAIDEN NAME Emma Feldman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Peritoneal hemorrhage DUE TO Thrombocytopenia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Reticulum Cell sarcoma (b) 4 Months (c) 3 Years		INTERVAL BETWEEN ONSET AND DEATH 20 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 3, 1961 to March 2, 1961 , that (I) (we) last saw the deceased alive on March 2, 1961 , and that death occurred at 1:00PM from the causes and on the date stated above.			
22a. SIGNATURE Martin J. Cline		22b. DATE SIGNED 3/2/61	
22c. PHYSICIAN'S NAME (Type) Martin J. Cline M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-5-61	
23c. NAME OF CEMETERY OR CREMATORY BETH DAVID CEMETERY		23d. LOCATION (City, town, or county) (State) ELMONT L.I. N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE B Danganby & Sons		25a. REC'D BY REGISTRAR MAR 6 '61	
ADDRESS 3501-14th St NW		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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New York

Montgomery

New York

28 days

Belgium

210-10 2nd Ave. (between 7 Stages 12

The Clinical Center

Belgium

(born)

Belgium

March 2, 1911

March 2, 1911

White

Male

Belgium

Belgium

Belgium

Belgium

Belgium

Not available The Clinical Center, Belgium 12, 1st and 2nd

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Belgium 12, 1st and 2nd

March 2, 1911

1:00 PM

March 2, 1911

March 2, 1911

The Clinical Center, Belgium 12, 1st and 2nd

Belgium 12, 1st and 2nd

CERTIFICATE OF DEATH

Reg. Dist. No. **03285**

3297

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			c. LENGTH OF STAY IN 1b 5 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12608 Valley Wood Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First THOMAS Middle A Last KELEHER			4. DATE OF DEATH Month March Day 9 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1867	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Entomologist-Dept. of Agrct		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME John Keleher			14. MOTHER'S MAIDEN NAME Caroline Trunnell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. A INFORMANT Address Mary Theresa Motley-#2d.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Ruptured of arteries clotted aneurysm of abdominal aorta Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis (c) approx. 10-20 yrs.					INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from March , 1957 to March 9 , 1961, that I last saw the deceased alive on March 9 , 1961, and that death occurred at 11:15 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Ralph F. Patton		ADDRESS (Street, city or town, state) 8641-Colesville Road			
PHYSICIAN'S NAME (Type) Ralph F. Patton, M.D.		DATE SIGNED March 9, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-11-61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James Ryan, Inc.		ADDRESS 317 Penna. Ave., SE		24a. REC'D BY REGISTRAR W. R. 13 '61	24b. REGISTRAR'S SIGNATURE Carlton S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

03527

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Time of death: [illegible]
8. Cause of death: [illegible]
9. Place of death: [illegible]
10. Signature of physician: [illegible]
11. Signature of registrar: [illegible]
12. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3298

CERTIFICATE OF DEATH

Reg. Dist. No. 03286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>2 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland Nursing Home</u>				d. STREET ADDRESS <u>8813 Glenville Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>ROSE ALICE KERR</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-11-69</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Andrew J. Paddock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lauck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Horace J. Kerr</u> Address <u>8813 Glenville Rd S.S.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic vascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , <u>1959</u> , to <u>3/25</u> , <u>1961</u> , that I last saw the deceased alive on <u>3/24</u> , <u>1961</u> , and that death occurred at <u>3:50</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10111 COLESVILLE RD</u> DATE SIGNED <u>A. F. THIBADEAU</u> ACTUAL SIGNATURE <u>A. F. THIBADEAU</u> M.D. <u>SILVER SPRING, M.D.</u> PHYSICIAN'S NAME (Type) <u>A. F. THIBADEAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-28-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>		22d. LOCATION (City, town, or county) (State) <u>Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ga Ave N.W.</u>				24a. REC'D BY REGISTRAR <u>MAR 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 should be executed. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 15 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				d. STREET ADDRESS 8505 14th Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Gertrude Klindworth				4. DATE OF DEATH Month Day Year 3 13 1961							
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/30/92		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work or occupation during working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Reymer's Candy Co.				11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anton Riester				14. MOTHER'S MAIDEN NAME Elizabeth Engelhardt Ochsenhirt							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary thrombosis 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of right patella DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH sudden 15 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) reported fell on pavement on front of her home							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 p.m. 2/26/61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Hyattsville, PG		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 3/14/61			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/16/61		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY				22d. LOCATION (City, town, or country) (State) WASHINGTON, D.C.			
23. FUNERAL DIRECTOR RAYMER E. PUMPHREY, INC. Raymond E. Ziska				ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE MAR 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

03287

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. If the deceased is not to be buried, cremated, or removed, and in any event within 72 hours after death, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18 & 21, Film 283
3-20-61
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03288
danca before address

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. & Hospital</i>		d. STREET ADDRESS <i>10406 Truxton Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Patricia Anna Kline</i>		4. DATE OF DEATH <i>March 12 1961</i>		9. AGE (In years last birthday) <i>19</i> yrs.	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3-21-41</i>		9. AGE (In years last birthday) <i>19</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>D. C.</i>	
13. FATHER'S NAME <i>Charles Kline</i>		14. MOTHER'S MAIDEN NAME <i>Anna V. Nelson</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-38-1517</i>		17. INFORMANT <i>Hospital Admitting Record</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>970.3</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Aspirin poisoning</i>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Reported to have taken 100-592 aspirins Tab</i>			
20c. TIME OF INJURY Month, Day, Year <i>2:30 PM 3-12-1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. City or town <i>Adelphi</i>		20g. (County) <i>Pg.</i>		20h. (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>3-12-61</i>	
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <i>W. W. Chambers Co. Riverdale, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-16-1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATH</i>	
22d. LOCATION (City, town, or country) <i>FT MYER</i>		22e. (State) <i>VA.</i>			
23. FUNERAL DIRECTOR <i>W. W. Chambers Co.</i>		24a. REC'D BY REGISTRAR <i>DATMAR 15 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

0328X

2300

THE STATE
DEPT. OF
HEALTH

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Address", and "City" are faintly visible.]

Division of

Health

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
3301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
03289										
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARY LAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			c. LENGTH OF STAY IN Ib 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			36		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,723 St. Paul Street					d. STREET ADDRESS 10,723 ST. PAUL STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDGAR (NMI) KRAHN					4. DATE OF DEATH Month MARCH Day 6 Year 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/1/94		9. AGE (in years last birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician		10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Lab.		11. BIRTHPLACE (State or foreign country) Lais, Estonia			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME August Krahn					14. MOTHER'S MAIDEN NAME Helene Freund					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 218-34-5461		17. INFORMANT Address Mrs. Dorothee Krahn 10723 St. Paul St.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease								INTERVAL BETWEEN ONSET AND DEATH sudden		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) FRANK J. BROSCHART					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED 3/6/61					
					Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/9/61		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR ARNER E. PUMPHREY, INC. Raymond A. Ziska					ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03299

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN lb <u>1/2 hr.</u>		d. STREET ADDRESS <u>2013 Lewisdale Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11105 Bucknell Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph John Kroto</u>		4. DATE OF DEATH <u>Mar 18 1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-7-05</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Ta</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Kroto</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Svuba</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213 34 3509</u>	
17. INFORMANT <u>Mrs Tillie Kroto Hyattsville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 22, 1961</u>	
22c. NAME OF CEMETERY OR BURIAL PLACE <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md;</u>		24a. REC'D BY REGISTRAR <u>MAR 22 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE	



[Faint, mostly illegible text from a medical certificate form, including fields for name, date, and location.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
3303 Items 23c & 23d, File G-283 3/21/61.cac. 03291											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 23 Days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS Box #6					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Anthony Middle Robert Last Landi						4. DATE OF DEATH Month March Day 8 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 26, 1912		9. AGE (In years lost birthday) yrs. 49		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Victor Landi						14. MOTHER'S MAIDEN NAME Theresa Pagni					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 194-01-6281		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410X DUE TO Rheumatic Heart Disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Mitral Insufficiency (c) Years Years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Surgery, Replacement of Mitral Valve											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that 41 (this hospital) attended the deceased from February 13 1961 to March 8 1961 , that 41 (we) last saw the deceased alive on March 8 1961 , and that death occurred 10:25 A.M. on the causes and on the date stated above.											
22a. SIGNATURE Benson R. Wilcox M.D.						22b. DATE SIGNED 3-9-61					
22c. PHYSICIAN'S NAME (Type) BENSON R. WILCOX, M.D.						22d. ADDRESS The Clinical Center National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 3-9-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Nicktown Cemetery		23d. LOCATION (City, town, or county) (State) Nicktown, Penna. Indiana, Pa.					
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.						25a. REC'D BY REGISTRAR DATE MAR 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3304

03292

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 119 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1763 Columbia Rd., N.W. - Apt. 51 d. STREET ADDRESS 47 X - 3													
3. NAME OF DECEASED (Type or print) Florence O'Toole		4. DATE OF DEATH Month March Day 15 Year 1961		5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-22-93		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 10		IF UNDER 24 HRS. Hours 15 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (County & State, or foreign country) Massachusetts				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Thomas E. O'Toole						14. MOTHER'S MAIDEN NAME Ellen Brown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none				17. INFORMANT (S) R. I. Lane, 1710 Glenkarney Pl., SS, Md.				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA, COLON 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO-SCLEROTIC HEART DISEASE 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 6 MOS.																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (it (this hospital) attended the deceased from Nov. 16 8:10PM to March 15, 1961 , that (a) (we) last saw the deceased alive on March 15, 1961 , and that death occurred at 8:10PM , from the causes and on the date stated above.																	
22a. SIGNATURE [Signature]				M.D. J. S. RYSKAMP, JR., LT, MC, USN				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22b. DATE SIGNED 3-16-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-20-61				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) Arlington Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska W. E. Humphrey Funeral Home, Silver Spring, Md.				ADDRESS Silver Spring, Md.				25a. REC'D BY REGISTRAR MAR 21 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

VR A15 (4)
15M 9/60

0328

330



District of Columbia

John G. ...

Washington

10 days

Postmaster (John)

1700 Columbia Rd. N.W. - Apt. 21

U. S. Naval Hospital

101

March 15

1943

10 days

Postmaster

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Postmaster

(1) R. I. Lane, 1710 Connecticut St., N.W., Wash., D.C.

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March 15

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March 15

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U. S. Naval Hospital, Bethesda, Md.

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Postmaster

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3305

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03293

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Philip		First Philip Middle Leet Last HECKEY		4. DATE OF DEATH Month 3 Day 16 Year 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 / 7 / 1907	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't City Post Office			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? Amer.			
13. FATHER'S NAME Samuel Rutherford				14. MOTHER'S MAIDEN NAME LOCHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. XXXXXX			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Rupture, and tamponade DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 hrs 15 hrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 1956 to March 16, 1961 , that (I) (we) last saw the deceased alive on March 15, 1961 , and that death occurred on 5 AM , from the causes and on the date stated above.							
22a. SIGNATURE James M. Whitlock				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-16-61	
22c. PHYSICIAN'S NAME (Type) JAMES M. WHITLOCK				22d. ADDRESS 7717 Canoll Ave Takoma Park Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/18/61		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Loudon County, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

10000

CERTIFICATE OF DEATH

3303

(M)

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death" are faintly visible.]

[Faint text at the bottom of the page, possibly a signature line or official stamp area.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3306

CERTIFICATE OF DEATH

03294

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY IN 1b <u>2hrs 45min</u>				d. STREET ADDRESS <u>3623 Aiton Place N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GERALD</u>		First Middle Last <u>LEHMANN</u>		4. DATE OF DEATH <u>MARCH 25 1961</u>		Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/18/91</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Theatre Owner</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Mississippi</u>			
12. CITIZEN OF WHAT COUNTRY? <u>Mississippi</u>							
13. FATHER'S NAME <u>LOUIS LEHMANN</u>				14. MOTHER'S MAIDEN NAME <u>LENA LEHMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Record</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>about 5 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from <u>March 18 1961</u> to <u>March 25 1961</u> , that (I) (we) last saw the deceased alive on <u>March 25 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul Eanet</u>				22b. DATE SIGNED <u>3-25-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAUL EANET</u>				22d. ADDRESS <u>6727-16th St. N.W. Wash. DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Canton Miss</u>		23d. LOCATION (City, town or county) (State) <u>Canton Miss.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3307

03295

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		
c. LENGTH OF STAY IN lb <u>4 hr</u>			d. STREET ADDRESS <u>6943 Decatur St</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P.E.P. Co. Generation Station</u>					
3. NAME OF DECEASED (Type or print) <u>Frank Andrew Lesko</u>			4. DATE OF DEATH <u>March 10 1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31 - 1918</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plumber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>
13. FATHER'S NAME <u>Andrew Lesko-577-10-7641</u>			14. MOTHER'S MAIDEN NAME <u>Robertson Boverman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>70-10-10-7641</u>		17. INFORMANT <u>Tom Cotton - P.E.P. Co.</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Blaschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. BLASCHERT</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED <u>3-10-61</u>		
			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 15, 1961</u>	22c. NAME OF CEMETERY OR CHURCH <u>Arlington National</u>	22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>		
23. FUNERAL DIRECTOR ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>MAR 16 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

NEW YORK
HEALTH DEPT.
NO. 1

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SECTION

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Collected by Dr. J. H. ...

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by the funeral director, and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3308

03296

1. PLACE OF DEATH a. COUNTY MONTG. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND		c. LENGTH OF STAY IN 1b 1 MOS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				d. STREET ADDRESS 3500-0 St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BELLA First Middle Last				4. DATE OF DEATH MARCH 21- 1961 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY-1-1893	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-48-5456		17. INFORMANT SAMUEL LEVIN		Address 3500-0-N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 10 weeks 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease, mitral stenosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1952 to 3/21 , 1961, that (I) (we) last saw the deceased alive on 3/21 1961, and that death occurred at 9:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Irving W. Winik				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/21/61	
22c. PHYSICIAN'S NAME (Type) Irving W. Winik				22d. ADDRESS 3900 McKinley St. N.W.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/23/61		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cem.		23d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Georgy J. J. Home				ADDRESS 4217-9th St. N.W.		25a. REC'D BY REGISTRAR DATE MAR 23 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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ST. LOUIS, MO.
JAN. 10, 1950

VR A15 (4)
15M 9/60

03297

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN b. 5 days		d. STREET ADDRESS 1804 28th Street, S. E.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Mathew LIESCH		4. DATE OF DEATH Month Day Year March 20 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-87
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob LIESCH		14. MOTHER'S MAIDEN NAME Emila BRASOLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) Yes WWI		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 156.1 DUE TO adenocarcinoma, liver, with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7-3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 15, 1961 to March 20, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20, 1961 , and that death occurred at 6:50AM , from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Linaweaver M.D.		22b. DATE SIGNED 3-20-61	
22c. PHYSICIAN'S NAME (Type or print) Paul G. LINAWEAVER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-23-61	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. Funeral Home		25a. REC'D BY REGISTRAR MAR 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	

03821

3303

Director of Columbia

Washington

2 days

Business (mail)

U. S. Naval Hospital

John

Madison

Albion

Wren

of

3-27-01

Communication

U. S. Navy

Office of the

Washington, D. C.

Office of the

Chief of the

Naval Records

None

None

For

only

Handwritten signature

March 20, 1901

March 20, 1901

March 20, 1901

John C. Linnam, Jr., U. S. Naval Hospital, Bethesda, Md.

3-23-01

Director of the

Washington

Virginia

Director of the, Federal Home, 1001 Good Hope Rd. SE

Washington

March 20, 1901

John C. Linnam

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3310

03298

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>312 Southwest Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Preston Brooks Longley</u>				4. DATE OF DEATH <u>MAR. 5 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/06</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor C&P</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Company</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greene, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willis Longley</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Brooks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-9148</u>		17. INFORMANT Address <u>Mrs. Adrienne J. Longley, 312 Southwest Dr. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Coronary Insufficiency</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>30-40 min</u> <u>5-6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1946</u> to <u>5 Mar. 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Feb. 20 1961</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>M.B. Queen</u>		22b. DATE SIGNED <u>3/6/61</u>	22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>				
22d. ADDRESS <u>7112 Willow Ave TAKOMA PARK, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Presbyterian Church Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Darnestown Montgomery Co. Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jiska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	25a. REC'D BY REGISTRAR DATE <u>MAR 9 '61</u>	25b. REGISTRAR'S SIGNATURE <u>C. J. ...</u>			

MEDICAL CERTIFICATION

2010

10/20/10

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3311

CERTIFICATE OF DEATH

03299

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 220 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 3412 S. Stafford e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Jones MARSH		4. DATE OF DEATH Month March Day 23 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-22
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 3 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry MARSH		14. MOTHER'S MAIDEN NAME Mae JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1940 to DOD		16. SOCIAL SECURITY NO. 272-18-8564	
17. INFORMANT (W) Mrs. Zoe A. Marsh, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) 157X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7-8 mos.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 15, 1960 , to March 23, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 23, 1961 , and that death occurred at 3P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Larry J. Hines M.D.		22b. DATE SIGNED 3-24-61	
22c. PHYSICIAN'S NAME (Type) Larry J. HINES, CDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-25-61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co. ADDRESS W.W. Chambers Co., 1400 Chapin St., NW, WashDC		25a. REC'D BY REGISTRAR MAR 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

008800

1155



U. S. Naval Hospital, Portsmouth, N.H.

James B. Jones, 300 days

James B. Jones, 300 days

James B. Jones, 300 days

James B. Jones, 300 days

James B. Jones, 300 days

James B. Jones, 300 days



James B. Jones, 300 days

James B. Jones, 300 days

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James B. Jones, 300 days

James B. Jones, 300 days

James B. Jones, 300 days

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3312

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 4 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resnor Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Chevy Chase d. STREET ADDRESS 4750 Chevy Chase Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles E. Mason		4. DATE OF DEATH Mar. 26, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1900
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Gov.		10b. KIND OF BUSINESS OR INDUSTRY Pub. Relations	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Nursing Home Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertention - C V A several mos. ago.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Mar. 26, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/61	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

0311

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3312

NAME OF DECEASED		MONTGOMERY, ROBERT A.	
AGE		30	
SEX		Male	
RACE		White	
DATE OF BIRTH		JAN. 10, 1900	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		None	
EDUCATION		High School	
MARRIAGE		Never married	
RELIGION		None	
CAUSE OF DEATH		Diphtheria	
MANNER OF DEATH		Natural	
PLACE OF DEATH		Home	
DATE OF DEATH		JAN. 23, 1931	
SIGNATURE OF EXAMINER		ROBERT A. MONTGOMERY	
TITLE OF EXAMINER		Medical Examiner	
ADDRESS OF EXAMINER		Baltimore, Maryland	
DATE OF EXAMINATION		JAN. 23, 1931	
SIGNATURE OF WITNESS		ROBERT A. MONTGOMERY	
TITLE OF WITNESS		Medical Examiner	
ADDRESS OF WITNESS		Baltimore, Maryland	
DATE OF WITNESS		JAN. 23, 1931	

3313
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03301

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 13 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BILLY Middle BEN Last McFARLAND, JR.				4. DATE OF DEATH Month MARCH Day 26 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/26/61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BILLY BEN McFARLAND				14. MOTHER'S MAIDEN NAME RACHEL FRANCES COLEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity and Immaturity 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atelectasis of lungs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/26 19 61 to 3/26 19 61 , that (I) (we) last saw the deceased alive on 3/26 19 61 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Richard A. Yates MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/27/61	
22c. PHYSICIAN'S NAME (Type) Richard A. Yates, M. D.				22d. ADDRESS Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-61		23c. NAME OF CEMETERY OR CREMATORY St. Paul		23d. LOCATION (City, town, or county) (State) Laytonsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

23 73 203 XV2

48881

CERTIFICATE OF DEATH

3113



Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible fragments include:

- NAME: ...
- DATE: ...
- PLACE: ...
- SIGNATURE: ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03303											
1. PLACE OF DEATH e. COUNTY <u>MONT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ednor</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DEL MONT NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>MONT.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DERWOOD</u> d. STREET ADDRESS <u>1 EDNOR, MD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ALTA MCILWEE</u>						4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-38</u>		9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>MUNSEY IND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ISSAC A. MCILWEE</u>						14. MOTHER'S MAIDEN NAME <u>WILLIS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ednor, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia - bilateral</u> 4120.0 DUE TO (b) <u>Chronic Heart Failure</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>17 Days</u> <u>4 MO.</u> <u>10 years.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>60</u> to <u>FEB 5</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>FEB 5</u> , 19 <u>61</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William Frank</u> 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK, M.D.</u>						22b. DATE SIGNED <u>11/18</u>		22d. ADDRESS <u>544 W. MONTGOMERY AVE</u> <u>ROCKVILLE, MD.</u>		22e. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Lutheran</u>		23d. LOCATION (City, town or county) <u>Star Tannery, Virginia</u>		(State)		25a. REC'D BY REGISTRAR <u>MAR 8 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis W. Barber</u>						ADDRESS <u>Laytonville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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William F. ...
Rockville, Md.

State of ...

March 6, 1901 St. James ...

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Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3316

08304

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>1 yr. 7 mos.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) ✓ a. STATE <u>Virginia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> d. STREET ADDRESS <u>2409 Menckin Drive - Apt. 203</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frances Callaway MC KELVY</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-15-99</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Callaway</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Daniels</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>(H) BGEN Wm. N. McKelvy, USMC, Ret., same as #2</u>				Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Breast with metastasis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 8, 1959</u> to <u>March 2, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>2:20 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>H. B. Townsend</u>				22b. DATE SIGNED <u>3-2-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. B. TOWNSEND, LT, MC, USN</u>				22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) _____ (State) _____ <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 6 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

3318

Montgomery

Beckwith (Hazel)

U. S. Naval Hospital

Francis

Constitution

Female

Homeless

Common Callaway

Home

No

W. J. D. Davis

USO

9-12-33

of

Callaway

10 KIRBY

March

6409 Monahan Drive - Apt. 203

1 yr. 7 mos.

Alexander

Virginia

R. A. Pumphrey, Federal Home, Bethesda, Md.

3-3-01

Washington National

Clinton

Virginia

O. B. Townsend, Lt, MC, USN

U. S. Naval Hospital, Bethesda, Md.

March 5

July 8

March 2

3-3-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3317 CERTIFICATE OF DEATH 03305

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Pennsylvania		b. COUNTY Chester	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 415 Evans Place		g. DATE OF DEATH March 20 19 61		h. MONTH March	
3. NAME OF DECEASED (Type or print) Richardson		4. DATE OF DEATH March 20 19 61		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-8-61		9. AGE (In years last birthday) 12		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richardson MC KNIGHT		14. MOTHER'S MAIDEN NAME Mary THOMAS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Richardson McKnight, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH at birth		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chester		(County) Pa.	
21. I certify that (this hospital) attended the deceased from March 10 1961 to March 20 1961, that (we) last saw the deceased alive on March 20 1961, and that death occurred at 11:10AM, from the causes and on the date stated above.		22a. SIGNATURE C. W. BRAMLETT		22b. DATE SIGNED 3-21-61		22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment-3-22-61		23b. DATE THEREOF 3-22-61		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City, town or county) Chester		(State) Pa.	
24 FUNERAL DIRECTOR'S SIGNATURE B. F. Taylor		25a. REC'D BY REGISTRAR DATE MAR 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hous		25c. ADDRESS WashDC		25d. SIGNATURE Arthur S. Hous	

(M)

(C)

0313

03303

Boothman (Moral)

1. Day

Chapman

U. S. Naval Hospital

U. S. Naval Hospital

Richardson

Richardson, Jr.

U. S. Naval Hospital

U. S. Naval Hospital

Richardson in flight

Richardson in flight

Name

(2) Richardson in flight, name of his plane

March 30

March 30

3-31-01

U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.

Green Dawn Cemetery

Chapman

H. R. Taylor Funeral Home, 40 Old St., N.H.

U. S. Naval Hospital, Portsmouth, N.H.

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3318

CERTIFICATE OF DEATH

03306

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Brooke Grove Foundation Inc</u>				d. STREET ADDRESS <u>9305 Flower Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Martha E. — McSorley</u>				4. DATE OF DEATH <u>March 31 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Newry Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Mgr. Dept. Store</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Edward Quinn</u>				14. MOTHER'S MAIDEN NAME <u>Anna Daly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Dorothy Quinn</u> Address <u>9305 Flower Ave Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis & occlusion & 420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO (c) <u>Sen. Art. Sclerosis & Senile</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 min</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-20-50</u> 19 <u>50</u> , to <u>31 Mar</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>28 Mar</u> 19 <u>61</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dorothy B. Ziegler</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>	
22d. ADDRESS <u>OLNEY, MD.</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>4/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FERNWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>FERNWOOD, DELAWARE CO., PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC. Raymond A. Zicka</u>				25a. REC'D BY REGISTRAR <u>APR 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

M

I

05300

CERTIFICATE OF DEATH

0110

10

10

BRIDGE, BRIDGE, BRIDGE

BRIDGE, BRIDGE, BRIDGE

BRIDGE, BRIDGE, BRIDGE

BRIDGE, BRIDGE, BRIDGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3319

CERTIFICATE OF DEATH

03307

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 80 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
				d. STREET ADDRESS 6404 Shadow Road			
3. NAME OF DECEASED (Type or print) Milton Edward Miles				4. DATE OF DEATH Month March Day 25 Year 1961			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (County & State, or foreign country) Arizona		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Miles				14. MOTHER'S MAIDEN NAME Mae Cook			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) 1918 to 1958				17. INFORMANT (W) Wilma Miles, same as # 2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate wife DUE TO Conditions, if any, which gave rise to immediate cause (b) metastasis (c) 177X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 177X				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Jan 4 1961 to Mar 25 1961, that he (we) last saw the deceased alive on March 25 1961, and that death occurred at 850PM from the causes and on the date stated above.							
22a. SIGNATURE S.T. Knappenberger				22b. DATE SIGNED 3-25-61			
22c. PHYSICIAN'S NAME (Type) S.T. KNAPPENBERGER, LT, MC, USNR				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY				25a. REC'D BY REGISTRAR MAR 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL RECORDS: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3320

03308

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 13 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. d. STREET ADDRESS 5002 70'th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nicholas Leslie Molloy		4. DATE OF DEATH Month March Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-02
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enlisted		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	9. AGE (In years last birthday) 58 yrs.
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Molloy		14. MOTHER'S MAIDEN NAME Mary Horton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (W) Margaret Olive Molloy	
17. INFORMANT (W) Margaret Olive Molloy		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 12 , 19 61 to March 25 , 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 25 , 19 61 , and that death occurred 1912 PM from the causes and on the date stated above.			
22a. SIGNATURE John W. Davis		22b. DATE SIGNED 26 March 1961	
22c. PHYSICIAN'S NAME (Type) J. W. DAVIS, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City, town or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		25. REC'D BY REGISTRAR MAR 28 '61	
25. REGISTRAR'S SIGNATURE Arthur L. Hines			

100

10 March 1961

U. S. Naval Logistics, Boston, Mass.

THE CHIEF, IV

11231

U. S. DEPARTMENT OF AGRICULTURE, BUREAU OF PLANT INDUSTRY, WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M											
MONTGOMERY											
3321											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03309											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 36 1/2 hrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 1520 Potomac Ave., S.E.							
3. NAME OF DECEASED (Type or print) Mary Patricia MOORE				4. DATE OF DEATH March 18 1961				a. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-61		9. AGE (In years last birthday) yrs. 1		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ferrell MOORE				14. MOTHER'S MAIDEN NAME Katherine BERNSTINE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT (F) Wm. F. Moore, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Immaturity DUE TO (b) Prematurity (1 lb. 8 oz.) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from March 17, 1961 to March 18, 1961, that (X) (we) last saw the deceased alive on March 18, 1961, and that death occurred at 7:40 PM, from the causes and on the date stated above. 22a. SIGNATURE Fred W. Grello M.D. 22c. PHYSICIAN'S NAME (Type) Fred W. GREILLO, LT, MC, USN ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 3-19-61 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3-21-61 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION (City, town or county) (State) Washington, D. C. 24. FUNERAL DIRECTOR'S SIGNATURE Pope Funeral Home, 414 15th St., SE, WashDC 25a. REC'D BY REGISTRAR MAR 21 '61 25b. REGISTRAR'S SIGNATURE											

-2051252XV0

152

(1971)

U. S. Naval Hospital

STOCK MARKET MAIL

6904

svoda 51. 22. 1988, 1. 1. 1989 (1)

3-77-3

Accepted for publication 12 November 2003

344

U.S. Patent 4,000,000

2-51-E

Accepted for publication 12 November 2003

svoda 51. 22. 1988, 1. 1. 1989 (1)

- 91 -

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03310

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ETCHISON d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Garthburg R-2</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ETCHISON d. STREET ADDRESS <i>1 Garthburg R-2</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUSSELL GORMAN MOORE		4. DATE OF DEATH MARCH 6 1961		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farm		8. DATE OF BIRTH 12/31/1896		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME WUTHER JAMES MOORE				14. MOTHER'S MAIDEN NAME LYDIA EDNA WARFIELD				11. BIRTHPLACE (State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 217-36-6466				17. INFORMANT FAMILY Mrs. Russell Moore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH SUDDEN				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 3/6/61	
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor		22d. LOCATION (City, town, or country) Etchison Montgomery Md.			
23. FUNERAL DIRECTOR <i>Francis H. Barber</i> Laytonsville, Md.				24e. REC'D BY REGISTRAR DATE MAR 9 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

103240

233 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FARMER

LYDIA EDNA HARRIS

LOUTHER JAMES MOORE

PANAMA CITY, PANAMA, CANTON DE S

217-35-5165

NO

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CONGRATULATIONS

X

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FRANK J. DORCHART, M.D.

2000/2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03311

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		MARYLAND c. LENGTH OF STAY in lb 11 weeks		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 403 50th. ST. N.E. Apt 31 a. IS RESIDENCE ON A FARM? NO					
3. NAME OF DECEASED (Type or print) Fred Mandell		First Fred		Middle Mandell		Last MORRIS Jr.		4. DATE OF DEATH Month March Day 3 Year 19 61	
5. SEX Male		6. COLOR OR RACE Negroid		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-60		9. AGE (In years last birthday) yrs. 3 Months 29 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Fred Mandell MORRIS Sr.				14. MOTHER'S MAIDEN NAME Barbara Aloneze DYKES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Fred M. Morris, same as #2 above Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) meningitis DUE TO Conditions, if any, which gave rise to immediate cause (b) porencephalic cysts DUE TO (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 3 MOS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-14-60 to 3-3-61 , 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3-3-61 , 19 61 , and that death occurred at 10:28 PM from the causes and on the date stated above.									
22a. SIGNATURE Robert V. Rack, MD		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-3-61			
22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-8-61		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City, town or county) (State) S.E WASHINGTON D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE John T. STEWART		ADDRESS 30 Hst. N.W. WASH D.C.		25a. REC'D BY REGISTRAR MAR 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. K...			

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MINISTRY OF DEFENSE

MINISTRY OF DEFENSE

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Handwritten notes and signatures in the center of the page.

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U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

11-11-60

11-11-60

11-11-60

3324

CERTIFICATE OF DEATH

Reg. Dist. No. 03312

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		c. LENGTH OF STAY IN life Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Trail Last Mullican		4. DATE OF DEATH Month March Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1870
9. AGE (In years last birthday) yrs. 91		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail road emp.		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mulligan		14. MOTHER'S MAIDEN NAME Rachel Trail	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Bertie M. Hagan		Address -Derwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COLLAPSE OF HEART 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES MELLITUS DUE TO (c) HYPERTENSIVE HEMORRHAGIC HEART DISEASE 20YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD OSTEO MYELITIS OF LEFT LEG			INTERVAL BETWEEN ONSET AND DEATH ONE HOUR 2 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 24, 1956 to MARCH 10, 1961 , that I last saw the deceased alive on FEBRUARY 24, 1961 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenberger		ADDRESS (Street, city or town, state) DATE SIGNED 310 West Montgomery Ave. 3/10/61	
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-13-61	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935

CERTIFICATE OF DEATH

3354

Dec. 11, 1935
New York City
No. 1000

Thomas T. Sullivan

Age 61

Residence 1000

Occupation

Married

Place of death

Cause of death

Immediate cause of death

Underlying cause of death

Contributing causes of death

Medical history

History of present illness

History of previous illness

Signature of physician

Signature of registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

3325										03313																			
1. PLACE OF DEATH a. COUNTY Montgomery					b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 3 days					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					b. COUNTY A.A.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital										d. STREET ADDRESS 1235 C 25th Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last Judith Ann Nichols					4. DATE OF DEATH Month Day Year March 24 19 61																								
5. SEX Female					6. COLOR OR RACE Caucasian					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 2-15-61					9. AGE (In years last birthday) yrs. 1 7					IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----					10b. KIND OF BUSINESS OR INDUSTRY -----					11. BIRTHPLACE (County & State, or foreign country) Maryland A.A.C.					12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Ralph E. NICHOLS					14. MOTHER'S MAIDEN NAME Jewel Dean DOWLING DOWNING																								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. None					17. INFORMANT Hospital Records					Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.13 Malnutrition DUE TO (b) Fibrosystic disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										INTERVAL BETWEEN ONSET AND DEATH 2 hrs. Congenital					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21. I certify that (this hospital) attended the deceased from March 21, 1961 to March 24, 1961 that (we) last saw the deceased alive on March 24, 1961, and that death occurred at 11:25 AM, from the causes and on the date stated above.										22a. SIGNATURE Lawrence G. Throne					22b. DATE SIGNED 3-24-61					22c. PHYSICIAN'S NAME (Type) Lawrence G. THRONE, LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment					23b. DATE THEREOF 3-25-61					23c. NAME OF CEMETERY OR CREMATORY Perry Mount Cemetery					23d. LOCATION (City, town or county) (State) Pontiac Michigan														
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey					ADDRESS Bethesda, Md. R.A. Pumphrey Funeral Home 7557 Wisconsin Ave.					25a. REC'D BY REGISTRAR DATE MAR 28 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus														

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03314

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 12 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10412 Edgewood Ave.				d. STREET ADDRESS 10412 Edgewood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Myrtle Whitney Niles				4. DATE OF DEATH Month 3 Day 21 Year 1961			
5. SEX fe male	6. COLOR OR RACE w hite	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1877		9. AGE (in years) 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS WHITNEY				14. MOTHER'S MAIDEN NAME REBECCA NETHERCUTT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 261-14-5955		17. INFORMANT Address Mrs. Peggy Niles, 10,412 Edgewood Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of hypertension and CVA about 3 years ago						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 3/21/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/24/61		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 27 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. The certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03315

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>11119 Brandon Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Bernard Celemore Noyes</u>				4. DATE OF DEATH <u>March 11 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 7, 1910</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Lagginess</u>				14. MOTHER'S MAIDEN NAME <u>Viola Hursey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Wife Esther Noyes</u>				Address <u>Shome as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's disease</u> DUE TO (b) <u>201X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>8 yr</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-11-61</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>			
				24a. REC'D BY REGISTRAR <u>MAR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MEDICAL CERTIFICATION

0321

(M)

(1)

Next Page

Unknown

ROBERT A. FORD
BETHLEHEM, PA.
ROCKWELL, NEW JERSEY

CERTIFICATE OF ORIGIN

100



MADE IN

UNITED STATES



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3329

CERTIFICATE OF DEATH

Reg. Dist. No.

03317

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>45 minutes</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>"B" OAKES</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 27 1961</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>45</u>	11. IF UNDER 24 HRS. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Howard LeRoy Oakes</u>		14. MOTHER'S MAIDEN NAME <u>Natalie Estelle Spaid</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		
INFORMANT <u>Father</u>		Address <u>—</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature labor</u> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>acute hydrops</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>3/27</u> , 19 <u>61</u> , to <u>3/27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>J. E. Renshaw</u>		DATE SIGNED <u>1150 CONNECTICUT AVE. N.W. WASH DC</u>		
PHYSICIAN'S NAME (Type) <u>JOSEPHINE E. RENSHAW MD</u>		<u>1150 CONNECTICUT AVE. N.W. WASH DC</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-28-61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Imelia Carter (for B)</u>		ADDRESS <u>Suburban Hospital Bethesda, Md.</u>		
24a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

CERTIFICATE OF DEATH

3339

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 13

Signature: [Illegible]
Date: [Illegible]

3330

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03318

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 234</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11901 ANDREW ST.</u>				d. STREET ADDRESS <u>11901 ANDREW ST</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>T.</u> Last <u>OGLE</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/23/1881</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Doctor</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM T. OGLE (SR.)</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET DUNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. MARGARET M. OGLE</u>		Address <u>11901 ANDREW ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastro intestinal hemorrhage</u> 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arterio sclerosis - cerebrovascular accidents</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Tom</u> 19 <u>59</u> to <u>3-19</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-13</u> 19 <u>61</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Russell M. Tillet, Jr.</u>				22b. DATE SIGNED <u>3-19-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>RUSSELL M. TILLEY</u>				22d. ADDRESS <u>4701 - Mass. Ave. N.W. - D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>March 22-1961</u>		23b. DATE THEREOF <u>March 22-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes</u>		23d. LOCATION (City, town, or county) (State) <u>Silver Spring - Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
ADDRESS <u>254 Carroll St. N.W.</u>				DATE <u>MAR 21 '61</u>			

TO DEPT
please e
4 should

VS. A15ME
5M 7/59

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an
the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the f
forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be ret
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR
HEALTH

ay is necessary,
st director, Page
for your files
State Board of Health.

STATE
DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03319

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. SAN & Hosp</u>			d. STREET ADDRESS <u>1815 Slingston St</u>		
3. NAME OF DECEASED (Type or print) <u>Walter Arthur Olsen</u>			4. DATE OF DEATH <u>3-7-1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-94</u> <u>66</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WOOD WORKER</u>			11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>CABINET MAKING</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>OLAF OLSEN</u>			14. MOTHER'S MAIDEN NAME <u>Gnette Samuelson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes 1st WW.</u>			16. SOCIAL SECURITY NO. <u>023-12-8089</u>		
17. INFORMANT <u>MR Oliver Olsen</u>			Address <u>Same as deceased</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u>					
420.1 DUE TO					
(b) <u>Severe coronary artery arteriosclerosis</u>					
DUE TO					
(c) <u>Severe myocardial hypertrophy with clinical hypertension</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dislocation of the left elbow associated with auto accident</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driver of auto involved in accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>3:30 p.m. 3-7 1961</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>					
20f. (City or town) <u>Silver Spring Monty Md</u> (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 8 1961</u>					
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>March 10, 1961</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Eastwood Cemetery</u>					
22d. LOCATION (City, town, or country) (State) <u>Lancaster, Mass.</u>					
23. FUNERAL DIRECTOR <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW D.C.</u>					
24a. REC'D BY REGISTRAR <u>MAR 10 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Harris</u>					

MEDICAL CERTIFICATION

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1899.
ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS.
1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3332

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03320

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 1629 Columbia Rd., Argoone Apt's	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Frank PADGETT		4. DATE OF DEATH Month Day Year March 18 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-80
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles PADGETT		14. MOTHER'S MAIDEN NAME Margaret Keyes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret P. STEPHAN		Address Washington 16, D.C. 5304 Elliott Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis, cerebral (left middle cerebral)</i> DUE TO (b) <i>Arteriosclerosis, generalized</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) XXXXXX attended the deceased from <u>March 13, 1961</u> to <u>March 18, 1961</u> , that (I) XXXX saw the deceased alive on <u>March 18, 1961</u> , and that death occurred at <u>6:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <i>Russell Miller, Jr.</i> M.D.		22b. DATE SIGNED 3-19-61	
22c. PHYSICIAN'S NAME (Type) Russell MILLER, Jr. LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-22-61	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Early</i> Early-Wheatley Funeral Home, Alexandria, Va.		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

MEDICAL CERTIFICATION

(M)

3338

03382

Director of Columbia

Memorandum

Washington D. C.

2 days

Deborah (Hart)

1-11-60

U. S. Naval Hospital

March 19

2-10-60

1-11-60

Robert

1-11-60

1-11-60

1-11-60

Operation

1-11-60

U.S.

Virginia

Washington D.C.

Charles P. D. H.

Washington D.C.

1-11-60

1-11-60

(T)

March 19 1960

March 19 1960

1-11-60

U. S. Naval Hospital, Bethesda, Md.

Virginia

1-11-60

1-11-60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
3333
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03321

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mississippi b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Biloxi	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 47 West End Homes	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Kenneth Last Palmer		4. DATE OF DEATH Month March Day 1 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1960
9. AGE (In years lost birthday) 3 yrs.	IF UNDER 1 YEAR Months 3 Days 6	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kenneth R. Palmer		14. MOTHER'S MAIDEN NAME Dixie Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Congestion DUE TO Acute congestive failure following aortic-pulmonary anastomosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour 12 hours 24 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from February 13 1961 to March 1 1961 , that he (we) last saw the deceased alive on March 1 1961 , and that death occurred at 7:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. W. Gilbert		22b. DATE 3/2/61	
22c. PHYSICIAN'S NAME (Type) J. W. GILBERT, M.D.		22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIPPER 3-3-1961		23b. DATE THEREOF 3-3-1961	
23c. NAME OF CEMETERY OR CREMATORY SPARTA		23d. LOCATION (City, town, or county) (State) ILL.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO		25a. REC'D BY REGISTRAR 1400 CHAPIN ST	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE MAR 3 '61	

10334

STATE OF TEXAS

10334

IN SENATE,
January 11, 1911.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 12, 1909.
BY
J. M. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS BOOK CONCERN,
1911.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03322

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY in 1b <u>20yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>426 N. Frederick Ave.</u>				d. STREET ADDRESS <u>426 N. Frederick Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Samuel Harold Peddicord</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 61</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 27, 1895</u>			
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gardiner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>			
13. FATHER'S NAME <u>Thomas E. Peddicord</u>				14. MOTHER'S MAIDEN NAME <u>May allen Briggs</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Harold U. Peddicord. Rockville.Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar. 15, 1961</u>					
				Address (Street, city, town, or county) <u> </u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or country) (State) <u>Gaithersburg. Md.</u>			
23. FUNERAL DIRECTOR <u>Ernest C. Gartner. Gaithersburg. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

FOR MR. [illegible]
[illegible]



FOR MR. [illegible]

FOR MR. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3335 CERTIFICATE OF DEATH 03323											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHEATON c. LENGTH OF STAY IN lb 12 DAYS					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8031 EASTERN AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WHEATON NURSING HOME											
3. NAME OF DECEASED (Type or print) SHIRLEY		First Middle Last PERRY		4. DATE OF DEATH 3/29/61		Month Day Year 19					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/25/1903		9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (Country & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MAYER KERSUN					14. MOTHER'S MAIDEN NAME DORA OMINSKY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ISADORE A. PERRY 8031 EASTERN AVE., S.S., MD. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 199X IMMEDIATE CAUSE (a) CARCINOMATOSIS WITH INVOLVEMENT OF LEFT PLEURA, LIVER, AND SPLEEN, PRIMARY SITE UNDETERMINED DUE TO (b) 3 MONTHS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 2/6 1961 to 3/29 1961 , that (I) (we) last saw the deceased alive on 3/28 1961 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. 22a. SIGNATURE David Goldenberg M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 3/29/61 22c. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG M.D. 22d. ADDRESS 10620 GEORGIA, SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-31-61		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN FALLS CHURCH VA.		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS - 3501-14th ST. N.W. ADDRESS					25a. REC'D BY REGISTRAR APR 3 '61 DATE		25b. REGISTRAR'S SIGNATURE C. H. S. H. H.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3336

CERTIFICATE OF DEATH

03324

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4008 Quintana Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Mabelle Louise Pfleger</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 24, 1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau Engraving</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles A. Lanphear</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Pfuntner</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-14-7117</u>				17. INFORMANT <u>Washington Sanitarium and Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> DUE TO <u>CORONARY</u> (b) <u>THROMBOSIS, ACUTE, LEFT ANTERIOR DESCENDING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>PULMONARY EMBOLISM, RIGHT AND LEFT LOWER</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>11</u> <u>DAYS</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 17, 1961</u> to <u>MAR 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>MAR 7, 1961</u> , and that death occurred at <u>3:50</u> AM, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Robert B. Irey</u>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>				22d. ADDRESS <u>7105 Riggs Road, Hyattsville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>Mar. 11, 1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>				23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				25a. REC'D BY REGISTRAR <u>Mar 13 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>				25c. ADDRESS <u>5201 Cleveland Ave. Riverdale</u>							

02320

0336

11

1

105-14-1117

BURIAL Mar 11, 1961 National Memorial Park Falls Church, Virginia
Robert B. Ince 71st Regt Foot Infantry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Coroner notified and will approve.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
Montgomery		Bethesda		MARYLAND		District of Columbia	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Suburban Hospital				3517 Rodman St., N. W.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
ALLEEN O. PHILLIPS				MARCH 8 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White				Dec. 7, 1886	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Housewife						South Carolina	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alfred Owens				Frances Easterling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
No				None			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				INTERVAL BETWEEN ONSET AND DEATH			
4 20-1 DUE TO ACUTE MYOCARDIAL INFARCTION				6 HOURS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)				ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3-8 11:00 PM 3-8 1961, that (I) (we) last saw the deceased alive on 3-8 1961, and that death occurred at 11:00 PM, from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Youngblood M.D.				22b. DATE SIGNED 3-9-61			
22c. PHYSICIAN'S NAME (Type) Edward W. Youngblood				22d. ADDRESS Wisconsin & Western Avenue, Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		3/11/61		Cedar Hill Cemetery		Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Robert A. Pumphrey				MAR 14 '61			
ADDRESS				25b. REGISTRAR'S SIGNATURE			
Bethesda, Maryland				Arthur S. Hume			



3837

DEPARTMENT OF DEATH

0332

Director of Cemetery

WASHINGTON

3212 Wisconsin Ave., N.W.

Alfred

Phillips

Dec. 1, 1885

South Dakota

Business Address

San Diego

Business Address

Home

No

At the place where the

At the place where the

Place

3-2-10

10

3-2-10

Edward W. Phillips

Receivable & Western Avenue

Edward W. Phillips, Secretary, Salisbury, Maryland

Vol. 1-21

Robert A. Phillips, Secretary, Salisbury, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3338

Item 7 Film G282 3-17-61 et

Reg. Dist. No. 03326

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11112 Mitschnr Street		d. STREET ADDRESS 11112 Mitschnr Street	
3. NAME OF DECEASED (Type or print) First Middle Last PATRICIA ANN PHILLIPS		4. DATE OF DEATH Month Day Year March 8, 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 8, 1925
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY U. S.	
13. FATHER'S NAME Clarence Edward Frances		14. MOTHER'S MAIDEN NAME Mannix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 235-30-1983	
17. INFORMANT Sister		Address Mrs. Curran	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden Found on bedroom floor.		INTERVAL BETWEEN ONSET AND DEATH Sudden Found on bedroom floor.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 3-8-61	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/61	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE MAR 14 '61	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.MARYLAND DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3339 CERTIFICATE OF DEATH 03327

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 61 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 430 Ridge Road, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Linda Middle May Last Phyfer				4. DATE OF DEATH Month March Day 29 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 18, 1955	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.		IF UNDER 24 HRS. Months 5 Days 5 Hours 5 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bill S. Phyfer				14. MOTHER'S MAIDEN NAME Barbara M. Lowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 193.4 IMMEDIATE CAUSE (a) Neuroblastoma, Metastatic to Lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 18 Months DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) January 27, 1961, to March 29, 1961, that (I) (we) last saw the deceased alive on March 29, 1961, and that death occurred at 4:40 PM, from the causes and on the date stated above.							
21. I certify that (I) (this hospital) attended the deceased from January 27, 1961, to March 29, 1961 , that (I) (we) last saw the deceased alive on March 29, 1961 , and that death occurred at 4:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Robert B. Scoggins, M.D.				22b. DATE SIGNED 3-30-61			
22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 3/31/61		23b. DATE THEREOF 3/31/61		23c. NAME OF CEMETERY OR CREMATORY New Albany Cemetery		23d. LOCATION (City, town, or county) (State) New Albany, Mississippi	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE APR 3 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

3338

1. Name of Deceased

2. Sex

3. Age

4. Date of Death

5. Time of Death

6. Place of Death

7. Cause of Death

8. Manner of Death

9. Signature of Registrar

10. Signature of Medical Officer

11. Signature of Coroner

12. Signature of Police Officer

13. Signature of Burial Officer

14. Signature of Undertaker

15. Signature of Witness

16. Signature of Registrar

17. Signature of Medical Officer

18. Signature of Coroner

19. Signature of Police Officer

20. Signature of Burial Officer

21. Signature of Undertaker

22. Signature of Witness

23. Signature of Registrar

24. Signature of Medical Officer

25. Signature of Coroner

26. Signature of Police Officer

27. Signature of Burial Officer

28. Signature of Undertaker

29. Signature of Witness

30. Signature of Registrar

31. Signature of Medical Officer

32. Signature of Coroner

33. Signature of Police Officer

34. Signature of Burial Officer

35. Signature of Undertaker

36. Signature of Witness

37. Signature of Registrar

38. Signature of Medical Officer

39. Signature of Coroner

40. Signature of Police Officer

41. Signature of Burial Officer

42. Signature of Undertaker

43. Signature of Witness

44. Signature of Registrar

45. Signature of Medical Officer

46. Signature of Coroner

47. Signature of Police Officer

48. Signature of Burial Officer

49. Signature of Undertaker

50. Signature of Witness

51. Signature of Registrar

52. Signature of Medical Officer

53. Signature of Coroner

54. Signature of Police Officer

55. Signature of Burial Officer

56. Signature of Undertaker

57. Signature of Witness

58. Signature of Registrar

59. Signature of Medical Officer

60. Signature of Coroner

1
FOR STATE HEALTH DEPT. M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3340
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03328

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3106 Weller Rd.	
c. LENGTH OF STAY in 1b 2 1/2 min.		d. STREET ADDRESS Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daniel	First Daniel	Middle Beard	Last Pinnell
5. SEX m	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-14
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph T. Pinnell		14. MOTHER'S MAIDEN NAME Lillie Copanbauer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 235-18-4325	
17. INFORMANT Mrs Mildred Pinnell - wife		Address Same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 X Cerebral hemorrhage and massive laceration DUE TO (b) Bullet wound of the head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1 hour			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Reported to be self-inflicted bullet wound	
20c. TIME OF INJURY Hour e.m. 8:55 3-9 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Washington Montgomery Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 3-9-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT & BURIAL		22b. DATE THEREOF 3/9/61	
22c. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY		22d. LOCATION (City, town, or country) (State) ALVON, WEST VIRGINIA	
23. FUNERAL DIRECTOR WADNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03329									
1. PLACE OF DEATH COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i> d. STREET ADDRESS <i>11903 Dalewood Drive</i>				
3. NAME OF DECEASED (Type or print) <i>Burt De Forrest Plunadore</i>					4. DATE OF DEATH Month <i>March</i> Day <i>5</i> Year <i>1961</i>				
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>February 20, 1894</i>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>67</i> Years <i>67</i> Days <i>67</i> Hours <i>67</i> Min. <i>67</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Host record</i>				
11. BIRTHPLACE (State or foreign country) <i>Watertown, N. York</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Edward Plunadore</i>					14. MOTHER'S MAIDEN NAME <i>Florence Lowe</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>					16. SOCIAL SECURITY NO. <i>W.W.I.</i>				
17. INFORMANT <i>Host record</i>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i>									
Conditions, if any, which gave rise to immediate cause (b) <i>1 hr.</i>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED				
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
Address (Street, city, town, or county)					3-5-61				
22a. BURIAL, CREMATION, RECOVERY AT 46 months		22b. DATE THEREOF <i>3/7/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>		22d. LOCATION (City, town, or country) (State) <i>Arlington, Virginia</i>			
23. FUNERAL DIRECTOR <i>Wash. Co. 2201-14 Wash, 9, D.C.</i>					24a. REC'D BY REGISTRAR DATE <i>MAR 7 '61</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>		

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

M.O.

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

3-5-61

22a. BURIAL, CREMATION, RECOVERY AT 46 months

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

FOR FILE

IN BIRTH DEPT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3342

03330

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY 58X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millbury d. STREET ADDRESS 12 Middleton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys Middle Rosealene Last Poisant		4. DATE OF DEATH Month March Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1917
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 4 Days 13 Hours 13 Min.	11. IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Stamper, Sr.		14. MOTHER'S MAIDEN NAME Elizabeth Williamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 031-18-3176	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral insufficiency DUE TO (c) Rheumatic Heart disease, inactive		INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 6 yrs. 36 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **March 5, 1961** to **March 23, 1961**, that (I) (we) last saw the deceased alive on **March 23, 1961**, and that death occurred at **2:00 p.m.** from the causes and on the date stated above.

22a. SIGNATURE James L. Talbert 22c. PHYSICIAN'S NAME (Type) JAMES L. TALBERT, M.D.	22b. DATE SIGNED 3/24/61	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/25/61	23c. NAME OF CEMETERY OR CREMATORY Worcester, Mass.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 1400 Chapin St. Md.		25a. REC'D BY REGISTRAR DATE MAR 27 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

0330

CERTIFICATE OF DEATH

1941



Longevity

Married

10 days

10 days

The Clinical Center, University of Maryland, Baltimore, Md.

1000 North Street

Residence

Residence

Residence

X

Female

December 22, 1941

no other

none

no other

Robert H. H. H.

Robert H. H. H.

03-18-1941 The Clinical Center, University of Maryland, Baltimore, Md.

Cardiac failure

History of hypertension

Chronic heart disease, hypertensive

March 22, 1941

March 22, 1941

1941

The Clinical Center, University of Maryland, Baltimore, Md.

Robert H. H. H.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3343
03331
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HOWARD ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 138 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Underwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Daniel Last Quesenberry				4. DATE OF DEATH Month March Day 11 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 1, 1938	
9. AGE (In years lost birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A/2c U.S. Airforce				10b. KIND OF BUSINESS OR INDUSTRY Armed Forces		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Fountain Quesenberry				14. MOTHER'S MAIDEN NAME Cornelia Hylton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1958 - 61		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 204. / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic Myelogenous leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 Years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 24, 1960 to March 11, 19 61 that (I) (we) last saw the deceased alive on March 11, 19 61 and that death occurred at 1:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Rieselbach M.D.				22b. DATE SIGNED 3/12/61			
22c. PHYSICIAN'S NAME (Type) Richard E. Rieselbach M.D.				22d. ADDRESS National Institutes of Health The Clinical Center, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-16-60		23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) Portsmouth, N.H.	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				25a. REC'D BY REGISTRAR DATE MAR 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3344 MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03332

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 30 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4964 - 12th Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Emmett Quirk				4. DATE OF DEATH Month Day Year March 8 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1905	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer				10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Michael J. Quirk				14. MOTHER'S MAIDEN NAME Lillie Mobley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 20452 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Acute Lymphocytic Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 1 1/2 years						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 6, 1961 to March 8, 1961 , that (I) (we) last saw the deceased alive on March 8, 1961 , and that death occurred at 3:40 a.m. , from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Reiselbach				22b. DATE SIGNED 3/8/61		22c. PHYSICIAN'S NAME (Type) RICHARD E. REISELBACH, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL OR CREMATION REMOVED SPECIES		23b. DATE THEREOF 3-11-61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town, or county) (State) Colmor Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th Street N.E.				25a. REC'D BY REGISTRAR DATE MAR 10 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

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0533

CERTIFICATE OF DEATH

334

Decedent's name

Decedent's name

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The official center, between the

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The official center, between the

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05333

3345

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 113 Elm Avenue a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Emma Jane Raines First Middle Last				4. DATE OF DEATH March 19 1961 Month Day Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 28, 1877		9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Raines				14. MOTHER'S MAIDEN NAME Fannie Ellen Shakelford					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Elton M. Raines 113 Elm Ave.; Takoma Pk, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 17 Nov 1957 to 19 Mar 1961 that (I) (we) last saw the deceased alive on 19 Mar 1961 and that death occurred at 9:30 PM from the causes and on the date stated above.									
22a. SIGNATURE Thomas P Jagarty				22b. DATE SIGNED 19 Mar 61		22c. PHYSICIAN'S NAME (Type)			
22d. ADDRESS				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-22-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Georgia Ave., NW		25a. REC'D BY REGISTRAR MAR 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03334

3346

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville- Rural 4 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Addie M. Reddick		4. DATE OF DEATH Month 3 Day 28 Year 19 61					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29 1869	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Spurrier				14. MOTHER'S MAIDEN NAME Martha Biggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Claude Reddick		Address Poolesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) 10 years							INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 October, 1952 to 28 March, 1961 , that I last saw the deceased alive on 27 March, 19 61 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith		M.D. Barnesville, Md.		ADDRESS (Street, city or town, state) Barnesville, Md.		DATE SIGNED 29 March 61	
PHYSICIAN'S NAME (Type) Gordon M. Smith		Barnesville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3/31/61		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton				ADDRESS Barnesville, Md.		24a. REC'D BY REGISTRAR DATE APR 3 '61	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

3328

Montgomery

Maryland

Poolesville

Poolesville - born 4 yrs

Matthews Nursing Home

x

61

28

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91

May 22 1889

Beddick

M.

Abbie

xx

Female White

own home

Honolulu

U.S.A.

Maryland

Martha Biss

John B. Hunter

Poolesville, Md.

Claude Beddick

None

No

Barnesville, Md.

Gordon M. Smith

Barnesville

Monocacy

5/21/01

Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1, 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3347

03335

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 10 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee b. COUNTY Johnson city c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1315 South Roam Street d. STREET ADDRESS 1315 South Roam Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) B. Carroll REECE		4. DATE OF DEATH Month March Day 19 Year 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-22-89	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Congressman		11. BIRTHPLACE (County & State, or foreign country) Tennessee	
13. FATHER'S NAME John I. REECE		14. MOTHER'S MAIDEN NAME Sarah AMPLES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Louise G. REECE		Address Washington, D.C. May Flower Hotel Apt #475	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO Conditons, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from March 9 1961 to March 19 1961 , that (I) was last saw the deceased alive on March 19 1961 , and that death occurred at 6:55 AM on the causes and on the date stated above.			
22a. SIGNATURE Russell Miller Jr. M.D.		22b. DATE SIGNED 3-19-61	
22c. PHYSICIAN'S NAME (Type) Russell MILLER Jr. LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-61	
23c. NAME OF CEMETERY OR CREMATORY Monte Vista,		23d. LOCATION (City, town or county) (State) Johnson City, Tennessee	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler s & Sons, Washington, D.C.		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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U.S. Naval Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3348

03336

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3247 Chestnut St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julie Middle L. Last Reynolds		4. DATE OF DEATH Month March Day 16 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Nilsson		14. MOTHER'S MAIDEN NAME Olene Hansen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Dorothy R. Donegan		Address N.W. Wash, D.C. 3247 Chestnut St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Malignant Vascular Thrombosis 463X DUE TO Conditions, if any, which gave rise to immediate cause (b) Progressive Pulvic Phlebotrombosis 2° of Injury from fall (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fract. Rt. Hip joint 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell 3rd story & fract. Rt. hip. Remained in traction since	
20c. TIME OF INJURY Month, Day, Year Hour 10 a.m. Feb 25 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home (Resmor)		20f. (City or town) Washington (County) D.C.	
21. I certify that (I) (this hospital) attended the deceased from March 16 19 61 , to March 16 19 61 , that (I) (we) last saw the deceased alive on March 16 19 61 , and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James J. Foster M.D.		22b. DATE SIGNED 3/16/61	
22c. PHYSICIAN'S NAME (Type) JAMES J. FOSTER		22d. ADDRESS 1746 K St N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3/17/61	
23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery		23d. LOCATION (City, town or county) Ithaca, N.Y. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,		25a. REC'D BY REGISTRAR MAR 17 '61 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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D.C.

Washington

Records

Director, American Hospital

321 Y Street N.W.

Reynolds

White

2/17/33

White

Demark

none

Glenn Hansen

Glenn Hansen

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The Secretary, American Hospital

no

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U.S. DEPT. OF JUSTICE
DIVISION OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3349

CERTIFICATE OF DEATH

03337

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Warren ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional manor Sanitarium				d. STREET ADDRESS 82X-3			
3. NAME OF DECEASED (Type or print) First Minnie Middle E Last Ridgeway				4. DATE OF DEATH Month 3 Day 10 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/20/1874	
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 8 Days 10		11. IF UNDER 24 HRS. Hours 10 Min. 1961		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Clerk, war Dept			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Otho Y Ridgeway				14. MOTHER'S MARDEN NAME Sarah Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 331X			
17. INFORMANT George A. Gray, Jr.				Address 4740 Chevy Chase Dr. Chevy Chase MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Generalized arteriosclerosis. (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) Recent amputation of rt. thigh - Dry gangrene of left foot due to arteriosclerosis of iliofemoral. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from January 1961 to March 10, 1961 , that (I) (we) last saw the deceased alive on March 9, 1961 , and that death occurred on March 10, 1961 , from the causes and on the date stated above.							
22a. SIGNATURE George A. Gray, Jr. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22b. DATE SIGNED March 10, 1961							
22c. PHYSICIAN'S NAME (Type) George A. GRAY, JR. M.D. 22d. ADDRESS 4740 Chevy Chase Dr. Chevy Chase MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
23b. DATE THEREOF 3-12-61							
23c. NAME OF CEMETERY OR CREMATORY FREDERICK BUR. GRD.							
23d. LOCATION (City, town, or county) (State) WARREN COUNTY VA.							
24. FUNERAL DIRECTOR'S SIGNATURE MADDOX FUNERAL HOME ADDRESS FRONT ROYAL, VA.							
25a. REC'D BY REGISTRAR DATE MAR 14 '61							
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

10530

CERTIFICATE OF DEATH

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3350**03338**

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b (1)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Wilbur Stansbury Rinehart				4. DATE OF DEATH Month Day Year March 30 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/02	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY School Buildings		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Lewis Rinehart				14. MOTHER'S MAIDEN NAME Antonia Ritchie Sheckels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-6794		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary PARKINSONISM DUE TO (c) HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE 15 years							INTERVAL BETWEEN ONSET AND DEATH 10 HOURS 15 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) OLD CEREBRAL THROMBOSIS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 1958 to MARCH 30 1961 , that (I) (we) last saw the deceased alive on MARCH 29 1961 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Gordon Rosenberger				22b. DATE SIGNED MARCH 30, 1961		22c. PHYSICIAN'S NAME (Type) Gordon Rosenberger, M.D.	
22d. ADDRESS Rockville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d. LOCATION (City, town, or County) (State) Damascus, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Wolsanthe				25a. REC'D BY REGISTRAR DATE APR 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Montgomery General Hospital
No. 2
March 30, 1961
White
Wife
Dancer
Lewia Kinohart
Hospital Records
Gordon Rosenberger, M.D.
New York, N.Y.
New York, N.Y.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3351

CERTIFICATE OF DEATH

Reg. Dist. No. 03339

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarong Sanitarium Hosp</u>				d. STREET ADDRESS <u>2005 Lawrence St. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eula Elizabeth Robey</u>				4. DATE OF DEATH Month Day Year <u>March 28 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1888</u> 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worked for Bureau of Engraving</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pomoret Maryland</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry F. Robey</u>				14. MOTHER'S MAIDEN NAME <u>Higgie MARTIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>IRVING ROBEY - #2d.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Constrictive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>December, 1957</u> , to <u>3-28-</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3-28-</u> , 19 <u>61</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1429 University Blvd. W. Silver Sp.</u> DATE SIGNED <u>3-28-61</u>							
ACTUAL SIGNATURE <u>Aldo Vacca</u> M.D.				PHYSICIAN'S NAME (Type) <u>Aldo VACCA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-30-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JAMES T. RYAN, Inc.</u> ADDRESS <u>317 Pk One S.E.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Aldo Vacca</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

3352

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13340

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 8 MO.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7520 - MAPLE AVE.				d. STREET ADDRESS 7520 MAPLE AVE.			
3. NAME OF DECEASED (Type or print) Julia M. Rooney				4. DATE OF DEATH MARCH 24 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-75	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) MASS.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MICHAEL PITTS				14. MOTHER'S MAIDEN NAME JULIA MARY WHITE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. -		17. INFORMANT DOROTHY DOWD. Address SAME AS #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 331X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular hemorrhage DUE TO							
(c) Advanced Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 60 , to March 24 , 19 61 , that (I) (we) last saw the deceased alive on March 23 , 19 61 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Robert B. Ireay				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Robert B. Ireay	
22d. ADDRESS 7105 Riggs Rd. Hyattsville Md.				22e. REC'D BY REGISTRAR MAR 27 '61		22f. REGISTRAR'S SIGNATURE Arthur L. Kline	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-61		23c. NAME OF CEMETERY OR CREMATORY West Mount Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS 3821-14th N.W. Wash. D.C.							

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[illegible]

MICHAEL FITZ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3353

05341

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital,		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Illinois b. COUNTY Ford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Melvin d. STREET ADDRESS - - - - -	
3. NAME OF DECEASED (Type or print) Harold Eugene ROWCLIFF		4. DATE OF DEATH Month March Day 16 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-26-35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	9. AGE (In years last birthday) 25 yrs.
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cyril A. ROWCLIFF		14. MOTHER'S MAIDEN NAME Hazel V. BULL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1953 to DOD		16. SOCIAL SECURITY NO. 334-26-2833	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma, generalized 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) } DUE TO (c) }			INTERVAL BETWEEN ONSET AND DEATH 5 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 12, 1961 to March 16, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 16, 1961 , and that death occurred at 5:08 PM , from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Linaweaver		22b. DATE SIGNED 3-17-61	
22c. PHYSICIAN'S NAME (Type) Paul G. LINAWEAVER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment	23b. DATE THEREOF 3-18-61	23c. NAME OF CEMETERY OR CREMATORY Melvin Cemetery	23d. LOCATION (City, town or county) (State) Melvin Illinois
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Hanna			

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U. S. Naval Hospital,

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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3354

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03342

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Joseph Ryder</u>				4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-1900</u> 61 yrs.	
9. AGE (In years last birthday) <u>61</u>				10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) <u>Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>				13. FATHER'S NAME <u>John F. Ryder</u>			
14. MOTHER'S MAIDEN NAME <u>Maryb. Barry</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>579-07-6451</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor (malignant)</u> 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-15-1960</u> to <u>3-14-1961</u> , that (I) (we) last saw the deceased alive on <u>3-13-1961</u> , and that death occurred at <u>1:19</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Marion Bankhead</u>				22b. DATE SIGNED <u>3/14/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>				22d. ADDRESS <u>9241 Col. Blvd. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Giska</u>				25a. REC'D BY REGISTRAR <u>MAR 20 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3355

03343

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5913 Johnson Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Beatrice H. Sadler</u>		4. DATE OF DEATH <u>March 13 19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. COUNTRY OF BIRTH <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Sidney Boyle</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Boyle Yes</u>	
17. INFORMANT <u>Mr. Merrill Vaughn (Son in Law)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Generalized Cardiac</u> <u>442X</u> DUE TO <u>Vascular Cerebral - Hypertension</u> Conditions, if any, which gave rise to immediate cause (b) <u>Immediate Cause - Pulmonary Edema</u> (a), stating the underlying cause last. DUE TO <u>3 Days</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hematemesis 3-7-61</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>50</u> to <u>March 13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-13-61</u> , and that death occurred at <u>12:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>P.P. Andrews</u>		22b. DATE SIGNED <u>3-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>P.P. Andrews</u>		22d. ADDRESS <u>4201 Fessenden St. N. W. Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>MAR 16 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3356 **CERTIFICATE OF DEATH** **03344**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST GLEN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Nursing Home		d. STREET ADDRESS 3217 Fayette Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle DORA Last SAGE		4. DATE OF DEATH Month March Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/77
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES GUNTHER		14. MOTHER'S MAIDEN NAME ROSALIE unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Delmar W. Sage, 3217 Fayette Road		Address Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Diverticulitis, Severe 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Stasis, Colon DUE TO (c) Stasis, Colon		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left hemiplegia, old, stable		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) January 19 61 Mar 25 61	
21. I certify that (I) (this hospital) attended the deceased from January 19 61 Mar 24 19 61 to Mar 25 19 61 that (I) (we) lost saw the deceased alive on Mar 24 19 61 and that death occurred at 1:15 a M. from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau M.D.		22b. DATE Mar 25 1961	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		22d. ADDRESS 10609 Concord St., Kensington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 3/26/61	
23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) EVANSTON, ILLINOIS	
24. FUNERAL DIRECTOR'S SIGNATURE WANNER E. PUMPHREY, INC. Raymond D. Baska		25a. REC'D BY REGISTRAR DATE MAR 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

ADDRESS
SILVER SPRING, MD.

105-10

CERTIFICATE OF DEATH

105-10

(M)

(J)

105-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1, 2, and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
3357					03345				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Hazard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hazard d. STREET ADDRESS General Delivery e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Teresa Middle (None) Last Sampsell			4. DATE OF DEATH Month March Day 7, Year 19 61						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1960	9. AGE (In years lost birthday) yrs. 6	IF UNDER 1 YEAR Months 22	IF UNDER 24 HRS. Hours 22 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Roger Sampsell			14. MOTHER'S MAIDEN NAME Ruby Collins						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Cyanotic congenital heart disease, Complete trans- position of the great vessels; ventricular septal defect; patent ductus arteriosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 754 (c) 2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 6 months 22 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from February 23, 1961 to March 7, 1961 , that (I) (we) lost the deceased alive on March 7, 1961 , and that death occurred at 10:55 AM the causes and on the date stated above.									
22a. SIGNATURE Benson R. Wilcox M.D. 22c. PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D.				22b. DATE SIGNED 3/7/61 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 3-8-61		23c. NAME OF CEMETERY OR CREMATORY Nable Cemetery		23d. LOCATION (City, town, or county) (State) Hazard, Kentucky			
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				25a. REC'D BY REGISTRAR DATE MAR 10 '61		25b. REGISTRAR'S SIGNATURE William S. Finney			

9VVVVVVVVVV

3357

U.S. DEPARTMENT OF HEALTH

1944

1. Name of patient: [illegible]
2. Date of birth: [illegible]
3. Sex: [illegible]
4. Race: [illegible]
5. Address: [illegible]
6. City: [illegible]
7. State: [illegible]
8. Zip: [illegible]
9. Date of admission: [illegible]
10. Date of discharge: [illegible]
11. Name of attending physician: [illegible]
12. Name of hospital: [illegible]
13. Name of clinic: [illegible]
14. Name of laboratory: [illegible]
15. Name of X-ray department: [illegible]
16. Name of pathology department: [illegible]
17. Name of radiology department: [illegible]
18. Name of surgery department: [illegible]
19. Name of medicine department: [illegible]
20. Name of pediatrics department: [illegible]
21. Name of obstetrics and gynecology department: [illegible]
22. Name of ophthalmology department: [illegible]
23. Name of otolaryngology department: [illegible]
24. Name of dermatology department: [illegible]
25. Name of neurology department: [illegible]
26. Name of psychiatry department: [illegible]
27. Name of orthopedics department: [illegible]
28. Name of urology department: [illegible]
29. Name of cardiology department: [illegible]
30. Name of pulmonology department: [illegible]
31. Name of gastroenterology department: [illegible]
32. Name of nephrology department: [illegible]
33. Name of endocrinology department: [illegible]
34. Name of immunology department: [illegible]
35. Name of infectious diseases department: [illegible]
36. Name of oncology department: [illegible]
37. Name of hematology department: [illegible]
38. Name of clinical chemistry department: [illegible]
39. Name of clinical microbiology department: [illegible]
40. Name of clinical immunology department: [illegible]
41. Name of clinical pharmacology department: [illegible]
42. Name of clinical toxicology department: [illegible]
43. Name of clinical nutrition department: [illegible]
44. Name of clinical exercise physiology department: [illegible]
45. Name of clinical psychology department: [illegible]
46. Name of clinical sociology department: [illegible]
47. Name of clinical anthropology department: [illegible]
48. Name of clinical linguistics department: [illegible]
49. Name of clinical musicology department: [illegible]
50. Name of clinical art therapy department: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3358

CERTIFICATE OF DEATH

03346

1. PLACE OF DEATH a. COUNTY MONTGOMERY 91003 BRISTOL AVE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 SILVER SPRING			
c. LENGTH OF STAY IN 1b SIX YEARS				d. STREET ADDRESS 9603 Bristol Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9603 Bristol Avenue				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LYDIA JANE SAPHOS				4. DATE OF DEATH Month MARCH Day 22 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 16, 1890	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6		11. IF UNDER 24 HRS. Hours 7 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME REAMER H. ALSIP				14. MOTHER'S MAIDEN NAME LOTTIG KATHERINE LOTER (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 578-03-9608			
17. INFORMANT MR. STEPHEN SAPHOS				Address 9603 Bristol Ave., Silver Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER of UTERUS 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 7 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15, 1960 to March 22, 1961 that (I) (we) last saw the deceased alive on March 22, 1961 , and that death occurred at 1:03 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles J. Demas M.D.				22b. DATE SIGNED 3-22-61			
22c. PHYSICIAN'S NAME (Type) CHARLES JOHN DEMAS				22d. ADDRESS 1301 - Mass. Ave. - Wash. S. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/24/61		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR MAR 27 '61	
				25b. REGISTRAR'S SIGNATURE Anthony S. Kinross			

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3359

CERTIFICATE OF DEATH

03347

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 5104 7'th Street d. STREET ADDRESS 5104 7'th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Griffith Schell		4. DATE OF DEATH Month March Day 26 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-07
9. AGE (In years last birthday) 53 yrs.		10. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Schell		14. MOTHER'S MAIDEN NAME Mary Jenkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (W) 1015 111111	
17. INFORMANT Lois Schell (W)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adverse Circumstances during 183 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 1, 1961 , to March 26, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 26, 1961 , and that death occurred at 0353AM from the causes and on the date stated above.			
22a. SIGNATURE J. L. Beeby Lt. MC, USN		22b. DATE 3-26-61	
22c. PHYSICIAN'S NAME (Type) J. L. BEEBY LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-29-61	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 1400 Chapin St., N.W. Wash. D.C.		25a. REC'D BY REGISTRAR MAR 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



() 1000 1111111111111111

W. W. CRAWFORD CO., 1400 Cassin St., N.W. Wash. D.C.

03349

VR A15 (4)
15M 9/60

1380

(M)

Robert A. Wagner

Bohemia

2 days

They leave

Superior Hospital

Admission Ticket

Frederick

Bohemia

4/24/35

Washington, D.C.

James K. Wagner

Bohemia

John A. Wagner

Bohemia

None

Bohemia

(I)

Robert A. Wagner
Bohemia, Maryland
5/21/35
Proprietor Will Wagner
Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **03350**

3361

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>38 yrs</u>				d. STREET ADDRESS <u>1309 Dean Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Rose</u> Middle <u>Schottrodt</u> Last				4. DATE OF DEATH <u>March</u> Month <u>11</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Ainsworth</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-20-1318</u>		17. INFORMANT <u>Ruth Ashby</u> Address <u>309 Dean DR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>November 1960</u> to <u>March 11, 1961</u> , that I last saw the deceased alive on <u>10 March 1961</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Veirs Mill Rd.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Herman Chaganzini</u> M.D. PHYSICIAN'S NAME (Type) <u>Herman C. Chaganzini</u> <u>Rockville Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1331 E. Montgomery Avenue</u> <u>Rockville, Md.</u>				24. REC'D BY REGISTRAR <u>Arthur S. House</u> DATE <u>MAR 14 '61</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
1938

CERTIFICATE OF DEATH

1938

DATE OF DEATH		PLACE OF DEATH	
MAY 1938		BALTIMORE, MD.	
AGE		SEX	
100		M	
RACE		EDUCATION	
W		H	
OCCUPATION		MARRIAGE	
C		M	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SUICIDE	
INJURY		HOMICIDE	
OTHER		OTHER	
DATE OF BIRTH		PLACE OF BIRTH	
MAY 1938		BALTIMORE, MD.	
AGE		SEX	
100		M	
RACE		EDUCATION	
W		H	
OCCUPATION		MARRIAGE	
C		M	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SUICIDE	
INJURY		HOMICIDE	
OTHER		OTHER	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03351

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN lb. <u>1 hr.</u>				d. STREET ADDRESS <u>12406 Parker Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10620 GEORGETOWN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Irvin Robert Schreiber</u>				4. DATE OF DEATH <u>Mar 17 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-1-1914</u>	
9. AGE (In years last birthday) <u>46 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NEW HOMES</u>			
11. BIRTHPLACE (State or foreign country) <u>DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>USC</u>			
13. FATHER'S NAME <u>Morris E Schreiber (Dec)</u>				14. MOTHER'S MAIDEN NAME <u>Mary Black</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>518-03-2969</u>			
17. INFORMANT <u>Edith Schreiber - Sister</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO (b) <u>Myocardial Insufficiency</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2 hours</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from table in doctors office</u>			
20c. TIME OF INJURY Month, Day, Year <u>11:20 am 3-17 1961</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work <input type="checkbox"/> et work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Office</u>				20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/20/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Natl. Meow. Park</u>				22d. LOCATION (City, town, or country) <u>Falls Church, Va.</u>			
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>				24a. REC'D BY REGISTRAR <u>4217-9th Ave</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>				DATE <u>MAR 20 '61</u>			

MEDICAL CERTIFICATION

1930

1930

1930

(M)

(I)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I have" and "and" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3363

CERTIFICATE OF DEATH

03352

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5124 Wessling Lane				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5124 Wessling Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) William E Schumann		4. DATE OF DEATH Month March Day 4 Year 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/ 1876		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 3 Days 10		IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist				10b. KIND OF BUSINESS OR INDUSTRY Dentistry				11. BIRTHPLACE (County & State, or foreign country) Missouri				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William E. Schumann						14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Katharine G. Schumann-Wife-same 2d Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) arterio sclerotic heart disease (c) generalized arterio sclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour 19 o.m. 3/4 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) 3/4 (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2/20, 1961, to 3/4, 1961 , that (I) me last saw the deceased alive on 2/20/1961 , and that death occurred at 1 P.M. from the causes and on the date stated above.																	
22a. SIGNATURE H. F. Kreuzburg				22b. DATE SIGNED 3/5/61				22c. PHYSICIAN'S NAME (Type) H. F. Kreuzburg				22d. ADDRESS 7852 16th NW Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/7/61				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION (City, town or county) Silver Spring, Md. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR MAR 8 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

1963



Montgomery

Montgomery

Montgomery

Bedford

Bedford

512 Westing Lane

512 Westing Lane

William

William

March

March

Male

17/01/1975

Robert

William E. Schumann

Robert

None

Robert A. Humphrey Bedford, Maryland
Gates of Heaven Cemetery Silver Spring, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3368
CERTIFICATE OF DEATH

03356

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 23 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Clendenin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #4, Box 127 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patty Lyn Seabolt		4. DATE OF DEATH Month Day Year March 3, 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1958
9. AGE (In years lost birthday) 3 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie R. Seabolt		14. MOTHER'S MAIDEN NAME Wavie King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis & congestive heart failure 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cyanotic Congenital heart disease DUE TO (c) since birth			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Surgery			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 8, 1961 , to March 3, 1961 , that (I) (we) last saw the deceased alive on March 3, 1961 , and that death occurred at 11:18 a.m. , from the causes and on the date stated above.			
22a. SIGNATURE James L. Talbert 22c. PHYSICIAN'S NAME (Type) JAMES L. TALBERT, M.D.		22b. DATE SIGNED 3/3/61 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR 3-4-61		23b. DATE THEREOF 3-4-61	
23c. NAME OF CEMETERY OR CREMATORY REED'S CEMETERY		23d. LOCATION (City, town, or county) (State) AMMA WEST, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		25a. REC'D BY REGISTRAR DATE MAR 6 '61	
ADDRESS 1400 Chapin Sp...		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CENTRE OF CLIMATE

1988

10

Montgomery
Barthelme
The Clinical Center
January 8, 1988
Child
Charles R. Barthelme
The Clinical Center, Bethesda, MD, Maryland

[Faint, illegible text block]

January 8, 1988
The Clinical Center, Bethesda, MD, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3364

03357

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 1 4702 Essex Avenue							
3. NAME OF DECEASED (Type or print) First Elizabeth Middle C Last Searles				4. DATE OF DEATH Month March Day 31 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1868	
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 10 Days 20		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Peter F. Causey				14. MOTHER'S MAIDEN NAME Jane E. Dickinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Dale C. Morgan-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO ARTERIOSCLEKOSIS GENERAL (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
INTERVAL BETWEEN ONSET AND DEATH 10 HRS. 5 Mo. 4 YRS.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 19 58 to MARCH 30 1961 , that (I) (we) last saw the deceased alive on MARCH 30 1961 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Leo M. Curtis				22b. DATE SIGNED 3-31-61			
22c. PHYSICIAN'S NAME (Type) Leo M. Curtis, M.D.				22d. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/3/61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City, town, or county) (State) Arlington, Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR APR 3 '61			
ADDRESS Bethesda, Maryland				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

1936



DECEASED

RESIDENCE

CHURCH OF THE LIVING GOD

CHURCH

1936

HOUSEWIFE

1936

None

No

1936

1936

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03358

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 23 Walker Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles A. Shaw		4. DATE OF DEATH March 9 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) 94 yrs.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorenal failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Open reduction fracture rt. hip DUE TO (c) Fall in his yard		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced arteriosclerosis general		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Was walking in back yard, fell fracturing right hip		20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 3/3 1961	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Gaithersburg Mont. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/10/61	
ACTUAL SIGNATURE Frank J. Broschart		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart		Address (Street, city, town, or county) Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 3-10-61		22c. NAME OF CEMETERY OR CREMATORY West Laurel Hill Cem.	
22d. LOCATION (City, town, or country) (State) Philadelphia, Penna.		23. FUNERAL DIRECTOR ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR MAR 17 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

3363 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
NEW YORK CITY

(1)

DECEASED

LAST NAME

FIRST NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

SIGNATURE

DATE

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 4 and 5 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03359

3370

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN lb 46 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert John Middle Robert Last Shipe				4. DATE OF DEATH Month MARCH Day 20 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/4/1889	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME CHARLES EDWARD SHIPE				14. MOTHER'S MAIDEN NAME LUCY LEE CUNNINGHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-1627		17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatitis Acute 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB. 5 1961 to 3-20 1961 that (I) (we) lost the deceased alive on 3-19 1961 and that death occurred at 4:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher M.D.				22b. DATE SIGNED 3/20/61		22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.	
22d. ADDRESS GAITHERSBURG, MD.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR MAR 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

05324

CERTIFICATE OF DEATH

1970

DECEASED: ROBERT A. HARRIS
DATE OF DEATH: 8/1/88
PLACE OF DEATH: HOSPITAL
CAUSE OF DEATH: HEART DISEASE
AGE: 65
SEX: MALE
RACE: WHITE
BIRTH DATE: 1/1/23
BIRTH PLACE: NEW YORK
MARRIAGE: MARRIED
SPOUSE: MARY HARRIS
OCCUPATION: FARMER
EDUCATION: HIGH SCHOOL
RELIGION: METHODIST
BURIAL PLACE: GREENWOOD CEMETERY
FUNERAL HOME: GREENWOOD FUNERAL HOME
DECEASED'S SIGNATURE: [Signature]
WITNESSES: [Signatures]
DECEASED'S ADDRESS: 1000 WHITE RD.
CITY: WASHINGTON
STATE: DISTRICT OF COLUMBIA
ZIP: 20000
DECEASED'S NEXT OF KIN: [Name]
ADDRESS: [Address]
CITY: [City]
STATE: [State]
ZIP: [ZIP]

DECEASED'S SIGNATURE: [Signature]
WITNESSES: [Signatures]
DECEASED'S ADDRESS: 1000 WHITE RD.
CITY: WASHINGTON
STATE: DISTRICT OF COLUMBIA
ZIP: 20000
DECEASED'S NEXT OF KIN: [Name]
ADDRESS: [Address]
CITY: [City]
STATE: [State]
ZIP: [ZIP]

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FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03353

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown				c. LENGTH OF STAY IN lb 10 hrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg (rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lone Pine Inn				d. STREET ADDRESS RFD # 3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Norman Shirley				4. DATE OF DEATH Mar. 20 19 61							
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July ? 1914		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Id.				11. BIRTHPLACE (State or foreign country) USA			
13. FATHER'S NAME Charles Shirley				14. MOTHER'S MAIDEN NAME Cora Johnson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Wellington Shirley RFD 3 Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO (b) Obstruction, Anterior Descending Coronary Artery Branch Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschert				M.D. Frank J. Broschert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschert				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Mar. 20, 1961			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/23/61		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove.,		22d. LOCATION (City, town, or country) Gaithersburg, Md.		(State)	
23. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE MAR 23 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3366
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03354

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY Greenville			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 401 Memorial Drive			
3. NAME OF DECEASED (Type or print) Mark SHIVERDECKER				4. DATE OF DEATH March 17 1961			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-24-61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Kent SHIVERDECKER				14. MOTHER'S MAIDEN NAME Marcia E. GAMBANCORTA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (F) David K. Shiverdecker, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septasemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Pylonephritis (c) Hydronephrosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) (1.) Malnutrition (2.) Absent, congenital, Rt. Kidney						INTERVAL BETWEEN ONSET AND DEATH 24 hr. 1 mo. Congenital	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from March 7 5:43 AM to March 17 1961, that (X) (we) last saw the deceased alive on March 17 1961, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Lawrence G. Thorne M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-17-61	
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 3-18-61		23c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery		23d. LOCATION (City, town or county) (State) Greenville Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS W.W. Chambers Co., 3072 M St., NW, WashDC		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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Ohio

Greenfield

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Richmond (Kent)

U. S. Naval Hospital

101 Hospital Drive

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3367

CERTIFICATE OF DEATH

Reg. Dist. No. 03355

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL SANITARIUM				d. STREET ADDRESS 3700 Dupont Avenue			
3. NAME OF DECEASED CARRIE BELLE First Middle Last				4. DATE OF DEATH Mar. 26 1961 Month Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/79	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESSMAKER			10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) ATLANTA, GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LEMUEL BRIGMAN				14. MOTHER'S MAIDEN NAME CARRIE GILLIAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. Jack W. Harville, 3700 Dupont Ave. Kensington, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebotrombosis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bladder tumor removed 7/60							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19			20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 13, 1961 , to Mar 23, 1961 , that I last saw the deceased alive on Mar 23, 1961 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Umhau				ADDRESS (Street, city or town, state) 8805 Conn. Ave. Chevy Chase 15 Md.			
PHYSICIAN'S NAME (Type) John B. Umhau				DATE SIGNED 5/26/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 3/29/61		22c. NAME OF CEMETERY OR CREMATORY RIVERSIDE CEMETERY		22d. LOCATION (City, town, or county) (State) ASHEVILLE, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE APR 3 '61	
				24b. REGISTRAR'S SIGNATURE William S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

3371

03360

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maine</u> b. COUNTY <u>Penobscot</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dexter</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Duburban Hospital</u>				d. STREET ADDRESS <u>255 Main St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Cowie</u> Last <u>Smart</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 22, 1888</u>			
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools Ill.</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>William Cowie</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>005-38-6-29</u>					
17. INFORMANT <u>Martin Anderson, 5913 Cheshire</u>				Address <u>Bethesda, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal Uremia</u> <u>153.8</u> DUE TO (b) <u>Intestinal Obstruction, Partial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Carcinoma of Colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive Carcinomatosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u> <u>5 days</u> <u>10 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1961</u> to <u>March 1961</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> 1961, and that death occurred at <u>8:50 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>James W. Long, M.D.</u>				22b. DATE SIGNED <u>3-28-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>JAMES W. LONG</u>				22d. ADDRESS <u>6601 - Frontenac Rd, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Dexter, Maine</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chuan Funeral Home</u>				ADDRESS <u>5103 Vin Ave Wash DC</u>		25a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>					

2586

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Montgomery		Bethesda		Maryland		Montgomery	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
6 1/2 days		Suburban Hospital		Bethesda		10130 Cedar Lane	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last Cleveland C. Smith				Month Day Year March 12 19 61			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W		3 - - 82	79 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired B & O. R.R. Trackman				Md.		Yes -	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Smith				Teresa Trail			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
No				705-097642			
17. INFORMANT				Address			
Jim Smith (son)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Dc. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				2Df. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-5, 1961, to 3-12, 1961, that (I) (we) last saw the deceased alive on 3-11, 1961, and that death occurred at 11:55 AM from the causes and on the date stated above.							
22a. SIGNATURE Sarah E. Glover M.D.				22b. DATE SIGNED 3-12-61			
22c. PHYSICIAN'S NAME (Type) Sarah E. Glover				22d. ADDRESS 10128 CEDAR LANE KENSING TOW, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		3/15/61		Monocacy		Beallville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
W.B. Hilton Barnesville				DATE MAR 16 '61			
				25b. REGISTRAR'S SIGNATURE Arthur L. Huns			

0330

DATE OF DEATH

0330



History

Residence

Employment

Education

Religion

Marital Status

3-12

11

11



Charles Smith
1000 1st St. S. E.
Atlanta, Ga.

Charles Smith

Charles H. Glover

Charles H. Glover
1000 1st St. S. E.
Atlanta, Ga.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3373

Items 2, 14, 22b Film G282 3-10-61 et

03362

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence Before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4606 4604 Springdale Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		4. DATE OF DEATH March 7 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-73	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (County & State, or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gustave SMITH		14. MOTHER'S MAIDEN NAME Leisha FOGLER, Elisa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1900 to 1919		16. SOCIAL SECURITY NO. 1900 to 1919	
17. INFORMATION Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Lower LOBE PNEUMONIA 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEVERE CORONARY ARTERIOSCLEROSIS with REMOTE INFARCTION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 9 1961 to March 7 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 7 1961 , and that death occurred at 3:32AM , from the causes and on the date stated above.			
22a. SIGNATURE Kenneth V. Harshman M.D.		22b. DATE SIGNED 3-7-61	
22c. PHYSICIAN'S NAME (Type) K. V. HARSHMAN, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons Funeral Home, Baltimore, Md.		25a. REC'D BY REGISTRAR MAR 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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U. S. Naval Historical

March 7, 1924

K. V. HAGERMAN, JR., MD

ANNALS STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3374

03363

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 1631 - 6th Street, N.W. Apt. #12							
3. NAME OF DECEASED (Type or print) First Hattie Middle (None) Last Smith				4. DATE OF DEATH Month March Day 27 Year 1961			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1904		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Padgett				14. MOTHER'S MAIDEN NAME Lizzie Burtons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 197-18-6985		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO ureteral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral ureteral obstruction & Pyelonephritis DUE TO Carcinoma of the Cervix (c) 10 days 1 year							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (he) (this hospital) attended the deceased from March 17, 1961 to March 27, 1961 that (we) last saw the deceased alive on March 27, 1961 , and that death occurred at 5:30PM from the causes and on the date stated above.							
22a. SIGNATURE Donald L. Morton				22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22c. PHYSICIAN'S NAME (Type) Donald L. Morton, M.D.	
22d. DATE 3/27/61		22e. DATE SIGNED 3/27/61					
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-31-61		23b. DATE THEREOF 3-31-61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat.		23d. LOCATION (City, town, or county) (State) Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons 4925 Plaine ave NE				25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE William L. Frank	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled in by the funeral director. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3375

CERTIFICATE OF DEATH

03364

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 82 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Ohio b. COUNTY Zanesville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2630 Dresden Rd. c/o Sharp d. STREET ADDRESS 2630 Dresden Rd. c/o Sharp e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roland Diehl SMITH		4. DATE OF DEATH Month March Day 14 Year 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-00
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finance		10b. KIND OF BUSINESS OR INDUSTRY ICA, State Dept.	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry C. SMITH		14. MOTHER'S MAIDEN NAME Minnie D. DIEHL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO. 274-16-0445	
17. INFORMANT (W) Mrs. Avis M. Smith, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 744.0 DUE TO TRACHEAL OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO BRONCHOPNEUMONIA DUE TO MYASTHENIA GRAVIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 22 1960 to March 14 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 14 1961 , and that death occurred at 9:15AM , from the causes and on the date stated above.			
22a. SIGNATURE W. L. DeBolt W. L. DEBOLT, LT, MC, USN		22b. DATE SIGNED 3-14-61	
22c. PHYSICIAN'S NAME (Type) W. L. DEBOLT, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 3-17-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR MAR 16 61 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TIME: 2 WEEKS

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Figure 4

Journal of Interpersonal Violence 20(1) 6-17

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3376 CERTIFICATE OF DEATH 03365											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE c. LENGTH OF STAY IN 1b 3 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4509 WOODLARK PLACE						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 4509 WOODLARK PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANNA First Middle Last 4. DATE OF DEATH MARCH 7 1961 Month Day Year											
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/7/88		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) GERMANY				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK GOTTACHAUCK						14. MOTHER'S MAIDEN NAME ELIZABETH unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Jean Walters, 4509 Woodlark Place Rockville, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from Jan 1 1961 to March 7 1961, that (I) saw the deceased alive on March 7 1961, and that death occurred at 8:20 A.M. from the causes and on the date stated above.											
22a. SIGNATURE P. L. Tabb, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/7/61			
22c. PHYSICIAN'S NAME (Type) S. L. TABB, M.D.						22d. ADDRESS 13,000 GA. AVE. S.E. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL				23b. DATE THEREOF 3/11/61		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town or county) (State) Middle Village, New York			
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Jaska						ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR MAR 10 61		25b. REGISTRAR'S SIGNATURE Arthur L. Hays	

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Mr. John Smith, 1200 Broadway, New York

NOTE

NO

Handwritten notes in cursive script, mostly illegible.

Handwritten note: "The above is a copy of the original."

Handwritten notes in cursive script, mostly illegible.

Miss Mary Smith, New York

St. John's Cemetery

St. John's Cemetery

St. John's Cemetery

St. John's Cemetery

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3377

CERTIFICATE OF DEATH

03366

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 39 Days			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 3303 Oberon Street		
3. NAME OF DECEASED (Type or print) Mildred Jacquelyn Summers First Middle Last			4. DATE OF DEATH March 3, 1961 Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1911		9. AGE (In years lost birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Griffith		
14. MOTHER'S MAIDEN NAME Ada V. Cross			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. Unascertainable			17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Inflow obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast DUE TO (c) Carcinoma of breast					INTERVAL BETWEEN ONSET AND DEATH 24 hrs Months Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from January 23, 1961 to March 3, 1961 , that (I) (we) last saw the deceased alive on March 3, 1961 , and that death occurred at 4:55 PM from the causes and on the date stated above.					
22a. SIGNATURE Benjamin J. Borowsky		22b. DATE SIGNED 3/4/61		22c. PHYSICIAN'S NAME (Type) Benjamin J. Borowsky M.D.	
22d. ADDRESS The Clinical Center		22e. ADDRESS National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION (City, town, or county) Rockville, Maryland		23e. LOCATION (City, town, or county) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

CERTIFICATE OF DEATH

3377

John Smith
Male
White
Born [illegible]
Died [illegible]
Cause of Death [illegible]
Place of Death [illegible]
Buried [illegible]
Signature [illegible]

Cardiac Failure
Obstruction
Arteriosclerosis of heart
[illegible]
[illegible]
[illegible]

Signature of Physician
[illegible]
[illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3378

0336

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11 Woodmoor Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) WALTER HENRY SWARTZ		4. DATE OF DEATH MARCH 25 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-03		9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed				10b. KIND OF BUSINESS OR INDUSTRY IOWA				11. BIRTHPLACE (County & State, or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel L. Swartz				14. MOTHER'S MAIDEN NAME Bertha Schwartz				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. Hospital Records				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebellar hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) 331X (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH 12 d.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1954 to March 25, 1961 , that (I) (we) last saw the deceased alive on March 24, 1961 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Abraham W. Danish				M.D. ABRAHAM W. DANISH		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-25-61		22d. ADDRESS 927 PERSHING Dr - SILVER SPRING									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Geo. Co. Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kenna				ADDRESS 254 Carroll St NW W.C.		25a. REC'D BY REGISTRAR MAR 28 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna											

MEDICAL CERTIFICATION

(M)

3378

(I)

James A. Smith

Self employed

Male

Single

3-7-53

1-0-54

South Carolina

Hospital records

3378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
3379 03368											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 40 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 915 Camden Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Renee Warfield TAXIS First Middle Last						4. DATE OF DEATH March 7 1961 Month Day Year					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-31-10		9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Rene WARFIELD						14. MOTHER'S MAIDEN NAME Marie PHIPPS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 575-16-8803		17. INFORMANT (H) BGEN S. G. Taxis, USMC, Ret., same as #2 Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, breast, with metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Jan. 26, 1961 to March 7, 1961, that (M) (we) last saw the deceased alive on March 7, 1961, and that death occurred at 11:35 AM, from the causes and on the date stated above.											
22a. SIGNATURE James J. Ryskamp, Jr. LT(MC)USN M.D.						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) J. J. RYSKAMP, JR., LT, MC, USN						22c. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22d. DATE 3-7-61		22e. SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-10-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 3012 M St. NW, Washington, D.C.						25a. REC'D BY REGISTRAR DATE MAR 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

03808

03808



Albuquerque, N.M. 10 days

Albuquerque, N.M. 10 days

Albuquerque, N.M. 10 days

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Albuquerque, N.M. 10 days

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3380

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03369

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Virginia</i> b. COUNTY <i>Arlington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>6 1/2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>723-22nd St. S.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Blanche</i> Middle <i>-</i> Last <i>Thomas</i>		4. DATE OF DEATH Month <i>March</i> Day <i>12</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21, 1872</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Cleveland Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William? Hewes</i>		14. MOTHER'S MAIDEN NAME <i>Cassella Baldwin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>atypical pneumonia left lung</i> 450.10 DUE TO <i>Fall & Dragging to left chest wall</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Smile given, cert. Sclerosis</i> (c) <i>16 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i> <i>16 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9-23-</i> <i>1954</i> to <i>3-12-</i> <i>1961</i> , that (I) (we) lost saw the deceased alive on <i>12 Mar</i> <i>1961</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>John B. Ziegler</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JOHN B. ZIEGLER</i>		22d. ADDRESS <i>Olney, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 15 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Laytonsville</i>		23d. LOCATION (City, town, or county) (State) <i>Laytonsville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Bashier</i>		25a. REC'D BY REGISTRAR <i>Mar 16 '61</i>	
ADDRESS <i>Laytonsville Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

CERTIFICATE OF DEATH

3380

11580

Blank form area for the Certificate of Death, containing various fields for recording information.

DATE OF DEATH: MARCH 12, 1961

PLACE OF DEATH: ALBANY

10331

CERTIFICATE OF DEATH

10331



NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

[illegible text block]

[illegible text block]

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3382

03371

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 209 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Trandafilos Ralph Traikos				4. DATE OF DEATH Month Day Year March 30, 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 15, 1915	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk				10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME A. Casto Traikos				14. MOTHER'S MAIDEN NAME Athena Geranderos			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 086-10-7189		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chondrosarcoma, Extensive DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from September 2, 19 60 to March 30, 19 61 that (I) (we) last saw the deceased alive on March 30, 19 61 and that death occurred at 4:10 PM on the causes and on the date stated above.							
22a. SIGNATURE Haskins K. Kashima M.D.				22b. DATE SIGNED 3-30-61			
22c. PHYSICIAN'S NAME (Type) Haskins K. Kashima M.D.				22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Bronx. N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Niles Co.				ADDRESS 2901-14th St. N.W.		25a. REC'D BY REGISTRAR DATE PR 3 '61	
				25b. REGISTRAR'S SIGNATURE Charles E. Hanna			

CERTIFICATE OF DEATH

1933

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3383 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03372

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md. Silver Spring c. LENGTH OF STAY IN 1b 6 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4010 Harvard St. Havard St.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md. Silver Spring d. STREET ADDRESS 4010 Harvard St. Havard St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Crawford Turner			4. DATE OF DEATH March 20th 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH January 28, 1886		9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of work life) Retender 11. BIRTHPLACE (State or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW #1 & #2		16. SOCIAL SECURITY NO. 113-20-9434		17. INFORMANT Mrs. Blanche Turner 4010 Harvard St. Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 Corona ry occlusion IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 420.1 Fell dead in bath room							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Mar. 21, 1961 ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. EXAMINER'S NAME (Type) Frank J. Broschart Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/24/61		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY			
22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA		23. FUNERAL DIRECTOR WERNER E. PUMPHREY, INC. SILVER SPRING, MD. ADDRESS					
24a. REC'D BY REGISTRAR DATE MAR 27 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>					

MEDICAL CERTIFICATION

85383

TOP SECRET

M

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1901, 12, 28

1901, 12, 28

1901, 12, 28

1901, 12, 28

may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3384

CERTIFICATE OF DEATH
Items 10b, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

03373

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY Georgia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 86 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Franklin Last Unglesbee		4. DATE OF DEATH Month March Day 1 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1908
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min. 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Factory Hotel	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clifford Unglesbee		14. MOTHER'S MAIDEN NAME Minnie Warfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-21-0442	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Multiple myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple myeloma DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December 5 1960 to March 1, 1961 , that (I) (we) last saw the deceased alive on March 1, 1961 , and that death occurred at 1:45 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Vincent H. Bono Jr.		22b. DATE SIGNED 3/1/61	
22c. PHYSICIAN'S NAME (Type) VINCENT H. BONO, JR., MD.		22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	23b. DATE THEREOF 3/3/61	23c. NAME OF CEMETERY OR CREMATORY Abby Cemetery	23d. LOCATION (City, town, or county) (State) Savannah, Georgia
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR MAR 2 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles S. Kneiss	

MEDICAL CERTIFICATION

2

1

2262

2006 2007 2008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3385

CERTIFICATE OF DEATH

Reg. Dist. No. 03374

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b 07 Gaithersburg, d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 07 Gaithersburg, d. STREET ADDRESS 7 James Street, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ward		4. DATE OF DEATH Month Day Year March 15, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1961
9. AGE (In years lost birthday) yrs. 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Carlton Wendell Ward		14. MOTHER'S MAIDEN NAME Sandra - Norson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unkown DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Partial Separation of Placenta DUE TO (c) 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Wallace N. McCune		M.D. 911 Silver Spring Ave., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Wallace N. McCune, M. D.		911 Silver Spring Ave., Silver Spring, Md.	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF March 16 1961	22c. NAME OF CEMETERY OR CREMATORY Wesley Grove	22d. LOCATION (City, town, or county) (State) Woodfield Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE MAR 17 '61		24b. REGISTRAR'S SIGNATURE Charles S. Krum	

CERTIFICATE OF DEATH

2135

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1915		BALTIMORE, MD	
AGE		SEX		RACE	
65		Male		White	
BIRTH		MARRIAGE		EDUCATION	
JANUARY 15, 1850		MARRIED		HIGH SCHOOL	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE	
MOTHER'S NAME		FATHER'S NAME		PREVIOUS ILLNESS	
MARY HARRIS		JAMES HARRIS		NONE	
MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF PHYSICIAN	
NATURAL		FILED		JAMES H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JANUARY 15, 1915		BALTIMORE, MD		HEART DISEASE	
AGE		SEX		RACE	
65		Male		White	
BIRTH		MARRIAGE		EDUCATION	
JANUARY 15, 1850		MARRIED		HIGH SCHOOL	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE	
MOTHER'S NAME		FATHER'S NAME		PREVIOUS ILLNESS	
MARY HARRIS		JAMES HARRIS		NONE	
MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF PHYSICIAN	
NATURAL		FILED		JAMES H. HARRIS	

RECORDED

INDEXED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3386

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 22b,c & d Film G283 3/27/61 iwk

03375

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>47X</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>D.O.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wash. San't Hospital</i>		d. STREET ADDRESS <i>143 Rhode Island Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gillard</i>		First <i>Gillard</i>		Middle <i>Watts</i>	
5. SEX <i>m</i>		6. COLOR OR RACE <i>C.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>GEORGIA</i>	
13. FATHER'S NAME <i>James Watts</i>		14. MOTHER'S MAIDEN NAME <i>Mrs. Betty</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp Record -</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE AND LACERATIONS</i> DUE TO (b) <i>MULTIPLE COMPOUND FRACTURES OF SKULL</i> DUE TO (c) <i>FALL FROM SCAFFOLD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell 22 ft from scaffold on construction job</i>		20c. TIME OF INJURY Month, Day, Year <i>2:00 p.m. 3-20 1961</i>	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>school construction Takoma Park Md</i>		20f. (City or town) (County) (State) <i>Huntville, Maryland</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>3-20-61</i>	
ACTUAL SIGNATURE <i>Frank J. Broschant</i>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>4611 Bending Rd. S.E. Wash. D.C.</i>	
22a. BURIAL, CREMATION, or other disposition (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-24-1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
23. FUNERAL DIRECTOR <i>MALVAN & SCHEY, INC. 424 "R" St., N. W.-Wash.,</i>		ADDRESS <i>D. C.</i>		24a. REC'D BY REGISTRAR <i>MAR 24 '61</i>	

1937

3388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
(10-11-37)

(M)

(T)

MADON & SONS, INC. 401 W. 11th St., N. D. 58001
D. C.
Monteville, Virginia
3-24-1901 3-24-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3387											
03376											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b Since 3/14/61 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 51 CHEVY CHASE d. STREET ADDRESS LAKE 3705 CHEVY CHASE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EUGENE			First Clayton Middle WEEKS Last			4. DATE OF DEATH MARCH 18 19 61			Month 18 Day 19 Year 61		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/9/88		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) SALESMAN Retired				10b. KIND OF BUSINESS OR INDUSTRY Royal McBee Typewriter Co.				11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Weeks						14. MOTHER'S MAIDEN NAME Kate Bunting					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) Army				16. SOCIAL SECURITY NO. 578-03-4728		17. INFORMANT Mrs. Ida M. Weeks, 3705 Chevy Chase Dr. Address Chevy Chase, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 17 mar 1961 to 3/18/61 , that (I) (we) last saw the deceased alive on 17 mar 1961 , and that death occurred at 3705 Chevy Chase Dr. from the causes and on the date stated above.											
22a. SIGNATURE William D. Aud						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/18/61			
22c. PHYSICIAN'S NAME (Type) William D. Aud						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3/21/61		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.						ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR MAR 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

08876

08876



3388

CERTIFICATE OF DEATH

Reg. Dist. No. 03377

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 614 Pershing Drive				d. STREET ADDRESS 614 Pershing Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARY RAY WATERS WELDEN				4. DATE OF DEATH March 15, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1924	
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John B. Waters				14. MOTHER'S MAIDEN NAME Mary Aileen Ray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Ryder Ray-200 N. Stonestreet Ave., Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia 578 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gastro intestinal hemorrhage DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 11, 1959 , to March 15, 1961 , that I last saw the deceased alive on March 14, 1961 , and that death occurred at 1:15 p. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron H. Traum				ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring, Md DATE SIGNED 3/16-61			
PHYSICIAN'S NAME (Type) Aaron Traum - 8237 Georgia Ave., Silver Spring, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/61		22c. NAME OF CEMETERY OR CREMATORY Grace Church Cemetery		22d. LOCATION (City, town, or county) (State) Woodside, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home				ADDRESS 1331 E. Montgomery Ave. Rockville, Maryland		24a. REC'D BY REGISTRAR DATE MAR 20 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

1. Name of deceased: *John A. Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 15, 1892*
5. Place of birth: *St. Louis, Mo.*
6. Usual residence: *1234 Main St., Baltimore, Md.*
7. Cause of death: *Heart Disease*
8. Date of death: *Dec 10, 1937*
9. Place of death: *Home*
10. Signature of physician: *Dr. J. H. Jones*
11. Signature of registrar: *Wm. H. Smith*

John A. Smith
1234 Main St., Baltimore, Md.
Dec 10, 1937
Heart Disease
Dr. J. H. Jones
Wm. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3389

CERTIFICATE OF DEATH

03378

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 54 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2633 12th St., N.E.	
3. NAME OF DECEASED (Type or print) Martha Coleman WOOTEN		4. DATE OF DEATH Month March Day 15 Year 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-04
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		12b. KIND OF BUSINESS OR INDUSTRY Private Industry	
13. FATHER'S NAME Robert WALSTON		14. MOTHER'S MAIDEN NAME Martha J. COBURN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. (S) James A. Wooten, same as #2 above	
17. INFORMANT (S) James A. Wooten, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure & uremia DUE TO (b) Carcinoma of the cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval BETWEEN ONSET AND DEATH: 36 hrs.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X (this hospital) attended the deceased from Jan. 20, 1961 to March 15, 1961 , that (X) (we) last saw the deceased alive on March 15, 1961 , and that death occurred at 3A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Arthur O. Anctil, Jr. M.D.		22b. DATE SIGNED 3-15-61	
22c. PHYSICIAN'S NAME (Type) Arthur O. ANCTIL, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) Edgecombe Co. No. Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE J.T. Rhines		25a. REC'D BY REGISTRAR MAR 21 '61	
24. ADDRESS 3015 12th St. NE, WashDC		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

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(1)

Non-Party

Director of Civil Affairs

Personnel (Civil)

Washington

U. S. Naval Hospital

3015 12th St., N.W.

Marine

Command

Woods

March 10

Marine

7-10-41

Marine Hospital

Marine Hospital

Private Hospital

U.S.

Marine Hospital

March 10, 1941

(2) 3015 12th St., N.W.

Handwritten:
Personal papers of the
Commander of the Corps

3015

Jan. 20 1941

March 10 1941

3-10-41

U. S. Naval Hospital, Bethesda, Md.

Marine Hospital

Marine Hospital

U. S. Naval Hospital, 3015 12th St., N.W., Washington

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03379

3390

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 4 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE NEW YORK b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW YORK CITY d. STREET ADDRESS 89X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) ROBERT RALEIGH YATES First Middle Last 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12/10/85 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAPT. U. S. NAVY 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) WARRENTON, VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.			4. DATE OF DEATH MARCH 6 19 61 Month Day Year 13. FATHER'S NAME HENRY CLAY YATES 14. MOTHER'S MAIDEN NAME ELIZABETH DESHIELDS		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW #2 & WW #1		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Benjamin R. Yates, Galleon House, St. Thomas Virgin Islands Address	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3-4X Pneumonia Stroke Cerebral arteriosclerosis IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 days 7-10 days Unknown	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
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21. I certify that (I) (this hospital) attended the deceased from **1957** **to** **3-6-** **1961**, **that (I) (the) last saw the deceased alive on** **3-6** **1961**, **and that death occurred at** **5:17 P.M.** **from the causes and on the date stated above.**

22a. SIGNATURE Morris Perry 22c. PHYSICIAN'S NAME (Type) MORRIS PERRY		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 11602 Georgia Ave. Wheaton 22b. DATE SIGNED	
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23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3/9/61		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	
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24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.		ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR MAR 15 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0833

3340



NEW YORK CITY

WASHINGTON

NEW YORK

FOR THE BOARD OF DIRECTORS

MARCH

WATER

PAID

ROBERT

DATE

WATER

X

WATER

WATER

CART. W. S. HAY

WASHINGTON, VIRGINIA

NEW YORK CITY

WASHINGTON, VIRGINIA

NEW YORK CITY

WASHINGTON, VIRGINIA

3-11-19
1-11-19
1-11-19
X

Provisional
State
Federal
District

1-11-19

1-11-19

X

1000 Georgia Ave. N.W.

Provisional

NEW YORK CITY

WASHINGTON, VIRGINIA

WASHINGTON, VIRGINIA

WASHINGTON, VIRGINIA

WASHINGTON, VIRGINIA

WASHINGTON, VIRGINIA

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03380

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
c. LENGTH OF STAY IN 1b Carrollton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrollton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 8506 Caswell Place,			
3. NAME OF DECEASED (Type or print) First Middle Last Young		4. DATE OF DEATH Month Day Year march 12, 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1961	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Charles William Young		14. MOTHER'S MAIDEN NAME Jeanetta Cora Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT father	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 759.3 DUE TO Congenital Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } DUE TO A Generalized edema (neck, body, scrotum) (c) unknown					INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) Hyattsville, Md.	(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 3/12/61 M, from the causes and on the date stated above.					
22a. SIGNATURE Herbert J. Friedel		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/12/61	
22c. PHYSICIAN'S NAME (Type) Herbert J. Friedel, M. D.		22d. ADDRESS 6826 Riggs Rd., Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3-15-61	23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Wash. San. & Hospital		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 16 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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CERTIFICATE OF DEATH

3331



Washington State Department of Health
Certificate of Death

Name: _____
Date of Birth: _____
Sex: _____
Race: _____
Marital Status: _____
Occupation: _____
Cause of Death: _____
Place of Death: _____
Date of Death: _____
Time of Death: _____
Signature of Physician: _____
Signature of Registrar: _____
Date of Registration: _____